NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

GENERAL INDEX.

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ORIGINAL ARTICLES.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. Reprints may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

WHAT ARE VITAL STATISTICS?*

By J. GEO. DEMPSEY, M.D., State Registrar.

Vital Statistics are the expression of *vital facts* by figures. A modern method of keeping accounts of humanity.

It is as necessary, and as important, to each nation, as the keeping of accounts by bookkeepers for the yearly balance.

Aristotle, the great philosopher, used statistics for describing and comparing different states.

In the year of 1662, church records of marriages, births and deaths were recorded in the City of London by John Gravert. In 1666 when plague prevailed lists of deaths and statistics were distributed through London.

In succession followed:

Italy (1767) by Gioja.
Boston (1793) by Shattuck.
France (1821) by Bertillions.

Each country added some illustrious person, contributing to vital statistics.

*Read before the Louisiana State Medical Society Meeting, April 11-13, 1922.

In European countries, they study human life from the cradle to the grave. The term Demography is applied. It is regarded as a science of the human generation, growth, decay and death, as studied by statistical method.

The principal major subjects include *Geneology, Human Eugenics, Census, Registration of Vital Facts, Vital Statistics, Biometrics* and *Pathometrics.*

Edmund Halley, the great astronomer, the discoverer of the planet, believed in statistics, and compiled in 1693 a series of mortality tables, and calculated the expected age of life, thus laying the foundation for scientific life insurance.

Some of the greatest scientists of the world have been enthusiastic statisticians, and in some cases their greatness has been due to their statistical skill.

During the war statistics were of great importance. These reports are found in the annual report of the Surgeon General of the United States of America.

America is a little behind these other countries in statistics, but I am proud to say that we have some worthy sons of the United States that few can compare with.

Pearson, Quiblet, Laplace, Jarvis, Shattuck, Abbott, Wright and many others that I cannot just now recall.

At present the United States Bureau of Census is urging the necessary reforms in the registration of vital statistics.

The first general census of the United States was made in the year 1790.

The U. S. Registration Area for Deaths was established by the Bureau of Census and published records and reports of mortalities in the year of 1880.

The U. S. Bureau of the Census in 1907 established a model law requiring 90% of all births and deaths to remain in the registration area.

The following states will be found in the Registration Area for Births and Deaths:

Washington, California, District of Columbia, Connecticut, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New York, North Carolina, South Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Wisconsin, Mississippi.

States for death only: Louisiana, Montana, Colorado, Florida, Illinois, Tennessee, Missouri and Nebraska.

Idaho and Wyoming are now being tested for births and deaths.

Montana, Colorado and Louisiana are now being tested for births.

	Per year.
Population of Virginia, approximately	2,306,361
Births received per year	72,000—31.2
Deaths received per year	27,600—11.9
Population of North Carolina, approximately	2,500,000
Births received per year	83,000—33.2
Deaths received per year	35,000—14.0
Population of Kentucky, approximately	2,445,000
Births received per year	
Deaths received per year	28,564—11.6
Doctors practicing	3,200
Midwives practicing	1,800
Population of Mississippi, approximately	1,789,618
Births received per year	43,000 to 44,000—24.6
Deaths received per year	30,000—11.2
Doctors practicing	1,700
Midwives practicing	4,000
Population of Louisiana, approximately	1,797,798
Births received per year (N. O. included)	37,192—18.7
Deaths received per year (N. O. included)	21,677—10.9

Doctors practicing 2,100—of these 1,780 are registered.
Midwives practicing 2,409—of these 171 are registered.
Louisiana is in the registration area for deaths.

I regret to say not for births, but through the earnest efforts and co-operation of the doctors, midwives and registrars, in all the parishes, we hope to have our beloved State, Louisiana, placed side by side with the other states that have gained this recognition.

Our efforts in securing complete certificates, no doubt, appeals to all practitioners. Our reward will be a place in the Registration Area of the Census Bureau at Washington, D. C.

The Department of Vital Statistics of the Louisiana State Board of Health was established July 12, 1914, which included all parishes outside of the City of New Orleans. Prior to that registration, some persons born in the country parishes were recorded in records of the City Board of Health of New Orleans. These records are still in their possession.

COMPLETE CERTIFICATES.

Certificates are only complete when fully made out and all questions answered.

TOTAL NUMBER OF BIRTHS REPORTED FOR THE YEAR 1920 (EXCLUSIVE OF NEW ORLEANS).

		White	Colored	Indian		Color Unknown		Doctor Attended		Midwife Attended or Other than Doctor		Still born	Midwives or Other than Doctors Attending Births in Each Parish in 1919
				M.	F.	M.	F.	W.	C.	W.	C.		
Acadia	734	549	185	0	0	0	0	324	13	225	172	39	83
Allen	403	287	116	0	0	0	0	248	58	39	58	19	16
Ascension	485	289	196	0	0	0	0	128	11	161	185	26	39
Assumption	271	122	149	0	0	0	0	92	14	30	135	16	33
Avoyelles	718	471	247	0	0	0	0	242	23	229	224	35	76
Beauregard	514	391	123	0	0	0	0	356	106	35	17	23	10
Bienville	310	213	97	0	0	0	0	200	35	13	62	7	21
Bossier	189	85	103	0	0	1	0	79	19	6	84	6	27
Caddo	1,639	1,029	610	0	0	0	0	972	185	57	425	111	70
Calcasieu	718	498	219	0	0	1	0	430	35	68	184	40	43
Caldwell	127	108	19	0	0	0	0	91	0	17	19	3	11
Cameron	71	59	12	0	0	0	0	32	4	27	8	0	14
Catahoula	258	177	81	0	0	0	0	138	6	39	75	10	32
Claiborne	306	168	137	0	0	1	0	158	64	10	73	17	43
Concordia	71	21	50	0	0	0	0	10	8	11	42	4	31
DeSoto	555	226	329	0	0	0	0	221	40	5	289	24	55
E. Btn. Rouge	1,069	577	492	0	0	0	0	489	52	88	440	81	55
E. Carroll	136	19	117	0	0	0	0	17	6	2	111	5	22
E. Feliciana	293	66	226	0	0	0	1	53	11	13	215	24	49
Evangeline	206	134	72	0	0	0	0	78	11	56	61	6	37
Franklin	343	238	105	0	0	0	0	223	18	15	87	13	15
Grant	215	160	55	0	0	0	0	150	9	10	46	9	8
Iberia	671	418	253	0	0	0	0	278	51	140	202	35	40
Iberville	689	326	363	0	0	0	0	195	16	131	347	44	64
Jackson	286	252	34	0	0	0	0	248	27	4	7	10	17
Jefferson	504	404	100	0	0	0	0	143	10	261	90	34	18
Jeff. Davis	377	295	82	0	0	0	0	240	16	55	66	15	13
Lafayette	810	490	320	0	0	0	0	298	31	192	289	23	64
Lafourche	1,084	886	193	3	1	0	1	254	18	632	175	46	77
La Salle	175	153	21	0	1	0	0	128	15	25	6	4	11

Lincoln	281	175	106	0	0	0	0	174	50	1	56	12	20
Livingston	330	288	42	0	0	0	0	195	13	93	29	6	23
Madison	62	26	36	0	0	0	0	23	0	3	36	3	14
Morehouse	293	104	189	0	0	0	0	82	19	22	170	7	48
Natchitoches	557	290	267	0	0	0	0	187	46	103	221	42	98
Orleans*	9,264	.....	.....	....	....	....	....	.....	4,373	....	4,891	538	....
Ouachita	573	362	211	0	0	0	0	317	22	45	189	35	40
Plaquemines	308	104	204	0	0	0	0	64	20	40	184	26	40
Pointe Coupee	461	174	287	0	0	0	0	96	33	78	254	18	72
Rapides	1,145	731	412	1	1	0	0	666	215	65	197	60	51
Red River	180	107	73	0	0	0	0	99	17	8	56	6	23
Richland	259	111	148	0	0	0	0	77	13	34	135	12	46
Sabine	457	387	70	0	0	0	0	378	50	9	20	18	17
St. Bernard	146	80	66	0	0	0	0	10	0	70	66	5	12
St. Charles	286	150	136	0	0	0	0	92	6	58	130	10	25
St. Helena	160	81	79	0	0	0	0	63	6	18	73	4	25
St. James	591	256	335	0	0	0	0	132	12	124	323	33	51
St. John	391	171	220	0	0	0	0	118	13	53	207	19	32
St. Landry	1,068	446	620	0	1	0	1	252	53	194	567	50	141
St. Martin	306	184	122	0	0	0	0	86	17	98	105	6	74
St. Mary	884	435	447	0	2	0	0	243	25	192	422	60	29
St. Tammany	393	257	136	0	0	0	0	106	38	151	98	18	41
Tangipahoa	637	485	152	0	0	0	0	424	34	61	118	29	37
Tensas	155	27	128	0	0	0	0	23	12	4	116	13	27
Terrebonne	594	396	194	2	2	0	0	61	6	335	188	23	56
Union	382	281	101	0	0	0	0	272	66	9	35	16	22
Vermilion	729	626	103	0	0	0	0	305	36	321	67	28	57
Vernon	418	328	89	0	0	0	1	300	71	28	18	16	9
Washington	370	284	86	0	0	0	0	246	33	38	53	25	26
Webster	406	230	176	0	0	0	0	212	43	18	133	18	51
W. Btn. Rouge	226	69	157	0	0	0	0	40	10	29	147	10	19
W. Carroll	135	126	9	0	0	0	0	106	3	20	6	7	19
W. Feliciana	187	26	161	0	0	0	0	21	3	5	158	18	46
Winn	331	277	54	0	0	0	0	257	13	20	41	17	11
*Totals	27,928	17,185	10,722	6	8	3	4	12,242	1,910	4,943	8,812	1,399	2,409

*New Orleans excluded.

It is often wondered why other states have so little trouble in receiving reports.

Answer: Many of the states pay physicians and midwives for each certificate besides paying the registrar.

A registrar is empowered to arrest a physician or midwife for not reporting on time, in some of the states, but in Louisiana it is quite different.

We have already called the district attorney's attention to the violation, but received no consideration, as he failed to act.

If the doctors would only respond promptly, they would assist us greatly.

All we ask is—"approximately," "probably"—what caused condition—"about"—or "I do not know."

Any of these terms can be applied in proper sense, so we can close the matter.

The questions are not asked to question the ability or veracity of our medical men, but for them to pass finally on cause of death.

In these modern days of record keeping, family connections, investigations made for research reference by medical bodies, insurance companies, government officials, a complete classification of record is necessary, otherwise Louisiana will remain in the position of a doubtful State.

A Word About the Doctors.

Few doctors are able to practice obstetrics in parishes, owing to the small compensation paid them for their services. Therefore, most of these cases fall to the lot of the midwife, and oft times an illiterate woman, who is unable to fill out these certificates.

To overcome this, we as medical men must encourage proper training and instructions through Public Health, Red Cross or Child Welfare Nursing.

A Few Facts About Still-Born Babies.

A child born dead is not registered as having been born. It is not included among either births or deaths—it is a stillbirth.

Should we consider all abortions or miscarriages stillbirths?

A child born alive and dies immediately is considered an infant. A birth and death certificate must be filled out to comply with the law.

Foetal deaths occurring before six or seven months of gestation are known as miscarriages, and are not reportable or recognized in ordinary statistical work. Those occurring later are stillbirths and must be reported.

Dr. F. V. Beitler, Chief of Bureau of Vital Statistics, Washington, D. C., has done some special work on abortions, all of which are included in stillbirths.

In conclusion, I want to thank all the doctors, registrars and midwives who are co-operating with us in this great work, also for your attention this evening.

THE DUTIES OF OFFICIALS RELATIVE TO PUBLIC HEALTH.*

By M. W. SWORDS, M.D., New Orleans.

Disregard or neglect on the part of officials throughout the State to assist in the enforcement of health laws prompts me to read this paper.

The health of a people is the fundamental foundation of success and happiness. Health is the greatest of all human assets and the most neglected.

In order to achieve success in health work, co-ordination of certain forces must be had, hence, health organizations through various agencies, as the State Board of Health, Parish and Municipal Boards have been legally organized and empowered to originate and enforce such health regulations deemed best suited to conserve public health.

The Legislature recently enacted a State law giving the Louisiana State Board of Health supervisory power over all boards throughout the State. Laws on the subject and the *modus operandi* of enforcement of same are ample. For this reason, it may appear to a casual observer that health problems could be easily disposed of and paramount benefits received through these agencies operating, but such is not all that it may seem.

The Louisiana State Board of Health has cause for disappointment because of the apparent lack of interest and appreciation of the legal authorities responsible for the enforcement of health laws.

I have known instances where the President of the State Board of Health has endeavored with earnestness and energy to bring

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*Read before the Louisiana State Medical Society Meeting, April 11-13, 1922.

to the bar of justice some wanton violator of health regulations with no success. Time and again, he has endeavored to interest courts, judges, district attorneys, grand juries, etc., officially to aid in the enforcement of just plain, simple violations without success. Officials of State, from the greatest to the least, seem to consider the enactment of health laws, minus enforcement, the only result to be obtained. Officials appear to consider the violation of health laws natural consequences and when urged to give assistance answer with a knowing smile that suggests the health officer compares favorably with the scenario professor chasing butterflies.

The Board of Health has never attempted to compel the constituted authorities to enforce health laws for the reason, I believe, that the board thinks their failure to co-operate is because of misinformation or lack of information on the subject.

Our laws are ample on the subject. We have means at hand to ensure reasonable success. We can enforce health regulations, but we lack the one essential for perfect achievement and that is the proper realization of the constituted authorities of their obligation to the people relative to the enforcement of health laws.

A mind may be bent towards legal matters, may be quick to comprehend the ordinary needs of folks, but no mind can understand the significance of health problems without time and study.

The authorities should carefully select health experts to handle health problems and the opinion of the health authorities should be the most important determining factor when courts are called upon to enforce health regulations and health laws.

The object of this paper is to call the attention of the medical profession to the fact that the health organization of the State, to my mind, is powerless to achieve the success that could be had if that body did receive the hearty support and co-operation of the State law enforcing power.

SOME PHASES OF RURAL HEALTH.*

By O. DOWLING, M.D.

There are three phases of rural health which seem especially pertinent for our consideration. These are:

1. Prompt reporting of births, deaths and communicable diseases.

2. Safe water supply, proper disposal of human wastes and measures of protection against insect carriers of disease.

3. A more definite understanding of the functions of the State and local health boards and the responsibility of each.

Of what use are certified reports of births and deaths? Why are these records so continuously stressed? We appreciate why the layman fails to grasp the importance of complete, accurate statistics, but it is inexplicable that their significance is not understood by all physicians. Doubtless, the numerous items of the certificates are irritating to the overworked and hurried country doctor; what difference does it make *who* was the father or mother or *where* they were born, or the occupation, or exact date of birth, or what time the patient was seen last. But these items have been agreed upon by an international conference. They have grown out of the experience of the civilized nations of the world.

The questions which so frequently arise even in local health offices are the best proof of the need for these data. Perhaps no statistics admit of so many analyses; certainly no figures are so completely differentiated and published as the vital statistics of countries which have a highly developed health department. Many states in this country publish an annual report of many pages of differentiated tables of mortality, birth and morbidity rates. Where the population is white and colored, it is even more imperative that the fatalities in age groups and other particulars for different diseases be classified and tabulated.

The Louisiana records of deaths for 1921 which have been received to date show 347 delayed 1921 death certificates. These together with the delayed 1920 death certificates would make a volume of about 500. Many of these reports were returned to the registrar or the doctor three, four or five times to have missing items of information supplied. Many would be amusing if the necessity for exactness were not so serious. For example,

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one certificate reads the person died of "dropsy" after having been treated by *mail* for several years. You may be interested to know the gross death rate for 1920 in Louisiana is 12. per thousand population. With present 1921 figures—not yet complete—the rate is 11:03. The urban rate is higher than the rural rate.

With a death rate of 12, Louisiana need no longer be afraid or ashamed to invite inquiry as to health conditions. The typhoid rates while much lower than formerly are still too high. In 1921, the total rate was 18.33 per 100,000 the total number of deaths being 334. The differentiated rates for 1920 are Urban 13.62, Rural 17.14. The tuberculosis general rate for 1920 is 131.83; for 1921 it is 113.40 (the latter incomplete). No comment is needed as you are aware the State does not provide any facilities for the care of these patients.

If anything, birth certificates are more difficult than death records. The reason is clear; both casket dealer and undertaker share responsibility with the physician for the reporting of a death and this extends the number of persons from whom information is obtained. Many births unattended by a physician, through ignorance of neglect, are never reported to the registrar and never reach the State Bureau. It is easy to see why a birth certificate has an individual value, but these statistics are also imperative if a state wishes to know its health progress, whether it is a growing or declining state and the outlook for its future. Our birth records are now being checked by agents from Washington and we hope they will find them satisfactory.

The reporting of communicable diseases is even more irritating to the busy doctor than the filling out blanks of a death or birth and as our budget is inadequate to properly finance this particular branch of the work, the writing and forwarding of the cards seem time and energy thrown away. What good does it do to report? Physicians generally agree that in the city the need and value of reports is obvious, but many can not see that the same factors are present in the small town or rural neighborhood. The claim is made that the population is scattered in the country, that diseases seldom become epidemic and, most forcibly, that nothing is ever done about it any way so what is the use.

While it is true that the outstanding epidemics usually occur in cities or towns, it is equally true that the great endemic reservoirs of infecion are the rural districts. A city by energetic means may entirely rid itself of a disease, the country round about will sooner or later supply a new infection. If we had only cities in the world, disease eradication and prevention would be a much simpler matter and many diseases would be rendered extinct. The city, of course, has the advantages of compact population, more money for the areas covered and, hence more efficient health organization, but the city today has a far greater advantage, one that should not exist. True, reported cases have many times been neglected, but organization for disease prevention is in a formative stage. The very best method to increase its efficiency is to show the need of it.

The statement is often made that contact is comparatively slight in country districts. No greater error was ever made. Contact is an exceedingly important factor in the rural spread of disease. To illustrate, recently a man contracted influenza away from home and returned with it to his house situated on a ridge running along the edge of a swamp. Five other homes were on this ridge at various distances covering altogether three or four miles. Shortly after his return home his wife developed influenza and then in progression, the disease invaded every home on the ridge attacking nearly all of the occupants. Tracing the contact was very simple, a kindly neighbor came over to cook while the man and his wife were both sick; she took sick and went home, others of her family contracted the disease, members from the other homes came over to see if they could help. Not so long ago there occurred in a community of three or four hundred inhabitants in Southern Louisiana an epidemic of 44 cases of typhoid fever. The community had had no typhoid for four years previously. The first case was imported, all the other cases were direct or indirect contact with the first and subsequent cases. Not one of these cases was ever reported by the attending physicians, the condition being brought to the attention of the State Board of Health by a layman. When apprised of conditions, the Board of Health promptly arrested the outbreak by anti-typhoid vaccination of the population in general, a procedure that would have been instituted very much sooner had these cases been reported.

In order to get more complete reports, the responsibility must be made plain. If a physician fails to report a case of communicable disease in his practice and other cases develop from the unreported case then the physician alone is to blame. When he reports this case he transfers the responsibility to the health officer. That the health officer may fail to do his duty is no excuse for the physician to fail to report.

To be more definite as to what use is made of these reports, on their receipt by the State Board of Health, the case is at once referred to the health officer concerned, whether city, town or parish, and he is urged to use every possible means to prevent further spread of infection. *In most instances the health officer takes such action.* That he does not always institute as widespread and complete measures as might be indicated is usually due to the fact that the community, whether parish, city or town, has *failed to provide the necessary funds.* This is the people's own fault and can not be charged against the health organization. Sometimes, we find an incompetent health officer. Generally, he retains his position only because his incompetence is not known to the public.

Only ignorance permits slipshod methods. When a disease is reported in an unusual number of cases at any point, the State Board of Health, according to the law, if necessary, may take direct charge. The idea that these reports are merely filed away is absolutely wrong.

The economic value of a system which can be relied upon for accurate data is well known to corporations having large investments, life insurance, real estate and manufacturing companies. Every few days, letters of inquiry are received asking health conditions, birth and death and morbidity rates. These are from persons who wish to come to Louisiana to live or do business. Our records may mean a new manufacturing plant, a colony, or a new citizen as the case may be.

The three chief problems of rural sanitation are the securing of a safe and adequate water supply, providing proper disposal of the body wastes, and securing protection against the insect carriers of disease, the fly and the Anopheles mosquito. While much has been done to improve conditions in these respects much yet remains to be accomplished. In many localities remedial measures are difficult and in some measure expensive; the main

reason that more is not done is the lack of knowledge on the part of the rural population regarding the role these factors play in the maintenance of health and the consequent lack of appreciation of the value of the right methods.

Many families continue to use water from shallow dug wells located where they receive seepage or surface washings contaminated by privies or barnyards when at a slight expense a new well could be driven, or a dug well constructed with tight curb and cover, and located remote from sources of contamination.

Hookworm is prevalent in many rural sections. Parents take it as a matter of course that babies and children shall suffer from diarrhea or "summer complaint" which often could more properly be called "fly complaint." In many places a simple pit privy, properly constructed, would answer all sanitary requirements and cost little more than the most insanitary surface closet.

Anopheline control whether by drainage to eradicate the mosquito or by screening, is somewhat expensive, but the cost is overbalanced by the gains due to increased productivity, savings of cost of medical service and medicines. The Anopheles is primarily a night-biting mosquito and where control of mosquito breeding is too expensive much good can be accomplished by the screening of dwellings, particularly of sleeping rooms. Reliance should not be placed on mosquito bars as a protective measure as these are not efficient.

The outstanding need in preventive medicine is education of the general public. The attending physician, on account of his direct personal contact at the moment when the minds of his clients are most receptive to such information, can accomplish untold good by simply-worded concise statements of the cause and sources of infection of the more common communicable diseases.

Act 79 of 1921 makes it mandatory that the Police Jury of the parish reorganize the parish board of health not later than the third regular meeting of the jury after this act became a law. The board must consist of three physicians, one school man and a fifth selected at the discretion of the jury. Should the Police Jury neglect to appoint or elect a Parish Board of Health within the sixty days after the passage of the act (which was November 18, 1921) a board shall be appointed by the State Health Officer (subject to the approval of the State Board) and when

approved the board so appointed shall have the legal authority of a board appointed by the Police Jury of the parish. The act provides that upon the expiration of the terms of office of present Municipal Boards, the Council shall appoint the Municipal Board. Three of these shall be physicians as in the Parish Board of Health and one a member of the municipal council. Failure to appoint within the given time, delegates power to the State Health Officer and the board as in the case of the parish. The term of service of the members are to correspond with that of the governing body which elects them.

The requirements as to personnel and the limitation in time as to appointments are the important changes. The effect has been to bring sharply to the consciousness of the Police Juries and city councils the fact that if they do not provide for a Board of Health there is authority vested in the State Board to do this. However, since the financing of the work depends upon the legislative bodies of the separate units it would be futile to name a board which would not meet with the approval of the Police Jury and the council, therefore, the selection as to personnel remains local after all. It makes little difference in whom the authority is vested; the main thing is that health service shall be standardized. And this will not obtain until sufficient funds are appropriated to make the salary of the health officer worth while with a guarantee of tenure of office dependent upon conscientious administration and progress in health work. To standardize schools and health we must place both, in organization and operation, above politics. For many years I have advocated this on every possible occasion and after almost twelve years of experience as State Health Officer I am more than ever convinced that it is impossible to reach a standard of excellence in these two lines of public service so long as political factionalism dominates or dictates policies or appointments.

The function of the State Board in relation to the local unit is largely advisory, but conditions may force the State Board to become for a time the director. In emergencies which the local board can not or will not handle, the State Board is empowered to act as it deems best. This, however, is limited to emergency work or to conditions which arise because of neglect or failure on the part of the local health officer or board. Often the State Board is urged to send immediately a specialist, to forward biological

supplies, to call upon the district attorney to act concerning some complaint—in a word, to do those things which come within the province of the local office unless the situation is beyond his control. In many instances it would be well to meet promptly these demands for promptness which in health work is all important. But the funds of the State Board are limited. The work planned is based largely on a process of selection of what seems most important. A program of work which would cover a number of years—the kind of program which would result in the greatest good—can not be undertaken because appropriations are made for only two years. The Legislature may give less or more—if the business can not count on a certain capital, then it can not undertake operations which must be budgeted in advance.

I wish to make this point plain because it is hard to refuse assistance when the necessity is urged by some health officer who, himself is without funds to meet the occasion. Free biologicals for the indigent should be provided, but the State Board has never had sufficient funds to guarantee this supply. Delay in use of anti-toxin, we have reason to believe, causes many deaths each year. If this were immediately available for the poor, the local health officer would be in a position to administer promptly which might not only prevent spread of the infection but save life.

The increased number of calls by wire or phone from rural districts is encouraging. It means that physicians more and more feel the responsibility for prompt use of these as protective agents and when the danger of delay in obtaining these products become a part of the community. conscience funds will be appropriated for this purpose.

In the interest of a better understanding of imperative activities there should be an annual conference of all health officers. It has been tried but where expense is not allowed by the governing body of the city and parish, the health officer can not be expected to attend. The budget item for health work is throughout the State deplorably inadequate, and if permission is given to pay expenses to a meeting, many health officers hesitate to use even a small amount for this purpose realizing how great the needs are for the more definite things which they find to do.

The health officer today in common with many conscientious physicians does not receive a proportionate reward for services rendered. If he serves it is because he has an understanding as to the civic and social value of his work, a respect for the ethics of his profession and an unconscious pride in doing good for the sake of good. It is not to the credit of our people that intelligent, educated, scientifically trained men should be expected to give their services and their time without adequate financial return—sometimes without even appreciation. I do not know of any body of men who wield more influence than the physicians of a State and I am convinced if we would unite to further public health each in his own locality we could create a demand for better pay for the efficient health officer and for full time service.

TYPHOID FROM A PUBLIC HEALTH STANDPOINT.*

By JOHN CALLAN, M.D., New Orleans.

While typhoid fever has diminished considerably in continental United States since 1910, as a study of the statistics for the registration area will reveal, yet it appears frequently enough in this area to be regarded as a public health problem which no health officer of town, city, county or State can afford to minimize.

In cities supplied with pure water and properly constructed sewers, the marked decrease of typhoid fever has been a source of encouragement to public health workers to renewed efforts to ferret and combat other sources of the infection.

There is no problem in public health where so much is known about the cause and the transmission which gives more difficulty in tracing to its infecting source than typhoid fever. We know fully that the bacillus typhosus is the only cause. It is well known that the cases are caused by the fecal evacuation or the urinary secretion of a previous case, entering the mouth and subsequently the gastro-enteric tract of the victim. That careless contacts, such as inmates and visitors of the infected house, physicians and nurses frequently contract the disease, is also well known. It is equaly true that careful people can nurse and care for cases without the slightest risk. That flies and other insects having access to the dejecta of a patient can and do infect foods

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*Read before the Louisiana State Medical Society Meeting, April 11-13, 1922.

of other people, many of whom fall victims to the disease, is well established.

It is common knowledge to the medical profession that quite a number of individuals after recovering evacuate for variable periods, some for life, the virulent bacilli of this disease. The statement has been made, there are others who, though never having been known to be sick with the disease, bacilli have been found in their stools. While having doubts about this, it is a source of comfort to believe if health officers had to deal with patients infected from such sources only the number of cases occuring would be negligible.

With these facts, as stated, the tracing of cases to their sources is yet difficult, because many foods furnish a pabulum to sustain the activity of the bacillus for a period sufficiently long for the infected material to be conveyed many miles from the point of its production. Handlers of food, other than those who produce it, if carriers, may and do infect this food by pollution from their hands. This is well understood if one keeps in mind the unfortunates, otherwise known as carriers, who constantly or intermittently eliminate virulent bacilli from their alimentary canal or with their urine. Milk furnishes a good culture media for the bacillus. Thus it is readily seen how a carrier in a dairy could spread disaster on a milk route.

Oyster beds can and have been infected where proper safeguards have not been thrown around them. Many states, noticeably New Jersey, New York and others have already realized this and have instituted the proper measures.

Fresh vegetables, especially those eaten raw, as celery, radishes, cresses, etc., have been a source of typhoid fever. Proper attention must be given to the production, handling and washing of such.

The typhoid fever reported in the City of New Orleans during the past three years is here repeated for your information:

Year	Cases Originating in City	Imported Cases	Total Cases
1919	120	39	159
1920	164	23	187
1921	93	58	149

Cases have been divided into those originating in the city and those brought to the city actually sick with the disease, or living

in the city for a period less than twenty-one days. My remarks will relate to those originating in the city, the infection source of the others being outside the jurisdiction of the City Board of Health.

Cases originating in the city were widely spread; sporadic, endemic or residual cases, as epidemiologists prefer to call them. Residual cases are those that spring up from time to time in different parts of a community which is supplied with pure water and properly constructed sewers. It seems almost impossible to trace or connect these cases with other cases. These, no doubt, are infected by intermittent carriers.

It will probably be of interest to cite our experiences in two particular instances in dealing with typhoid fever in New Orleans. As most of you are familiar with the city, it is sufficient to say that the greater number of houses are abundantly supplied with pure water and properly connected with sewers. Still there are some groups of people in the corporate limits of the city who have the water supply to their houses but the sewers have not yet been laid by their homes.

From a house in one such place, Edgewood, within 3½ miles of the city hall, a case of typhoid fever was reported on June 21, 1921. Realizing the possibility of a fly-borne outbreak developing from this case, at once the inspectors of the City Board of Health were instructed to sprinkle chlorinated lime in all the open privy vaults. Orders were given to repair all screens of these vaults which was promptly complied with. Re-inspections were made constantly until the cases which subsequently developed were dismissed from sanitary care. This was not done until the urine and feces of the patients were found free of the bacilli. Anti-typhoid vaccination of all who would submit, 248 in number, was hurriedly started. Concurrent disinfection was done in a perfunctory manner. Although the disease was confined to this house, five contact cases developed. This was a reflection, proving the failure of our concurrent disinfection. This failure determined the establishment of the Registered Trained Nurses in the Health Department of New Orleans.

On the 14th of December, 1921, it was announced to the board that there was only one active case of typhoid fever known to the health authorities at that time. It was a case which had

developed near the lower limits of the city and removed to the Charity Hospital.

On December 20th two cases were reported from a house in the upper part of the city, two days later two more cases from another house in the extreme upper part of the city. Cases followed in rapid succession until we ended the year with 9 active cases on the books. Cases were being reported in rapid succession in this area during the month of January, 1922. On February 6th the last case was reported. This was a contact case which developed in an infected house, the previous case being reported on January 5th.

It was quickly realized that there was an outbreak of typhoid fever which threatened serious proportions.

The financial conditions of these patients were such that all necessary equipment and assistance were provided, nearly all being supplied with trained nurses. Concurrent disinfection was at once explained to the nurses and occupants of the infected houses. Anti-typhoid vaccination of the contacts was urged. The vaccine was supplied by the City Board of Health. The physicians in attendance vaccinated the contacts. In some few instances the physicians of the board did the vaccination. Through the press the people of this section were advised to adhere strictly to cooked foods.

Wild rumors and street gossip promptly placed the cause to oysters. Oysters were traced from retailers to wholesalers and finally to the oyster beds without result. The oysters as the cause could be eliminated because the outbreak was limited to only a section of the city, while oysters were consumed by people living in every part of the city. Although it was thought timely to write the president of the State Board of Health the necessity of throwing some safeguard around those beds which are such a valuable industry to the State. Some people use oysters as a delicacy, while many use them as a food. If they ever become contaminated with the typhoid bacillus and cause an outbreak, serious sickness will result to many people which will also deal a severe blow to the oyster industry.

The water supply was carefully investigated. There had been no break down at any time in the filtration or chlorination of the water. The bacterial count had been continually low for periods too long for water to be considered as the cause. Even

water from taps in many of the houses was examined with the same negative results. Ice from retailers to manufacturers was traced with negative results. The scare was taken advantage of to have some suggestions for the better handling of ice instituted.

Milk was carefully investigated and was quickly eliminated. Various dairymen from widely scattered parts had supplied these homes. Many of these cases had for a long period used pasteurized milk and some used only condensed milk. The same factors eliminated the butchers and bakers.

Investigation of the vegetables was continued, even extending into the adjoining parish of Jefferson. There was revealed a condition that was an abomination to civilization, if not the actual cause of this outbreak. Vegetables were washed in wash holes connected with drains from the fields and in some instances privy vaults were over these drains in close proximity to these wash holes as close as four feet in some instances. Fecal matter, floating in these wash holes where these vegetables were washed, was seen by our inspectors. This state of affairs has been reported to the president of the State Board of Health. This particular place is immediately across the river opposite the section of the city in which the typhoid fever prevailed. Ferries constantly ply across the river at three points a mile apart in this section. Every morning wagons loaded with the produce of these truck farms cross on these ferries. Vegetables that are eaten raw, such as celery, lettuce, radishes and cresses from farms where human excrement have been used as a fertilizer have been recognized as causes of outbreaks. Is there any difference if the ground is fertilized with human excrement or that the vegetables are washed in solution of human filth? If so, certainly the greater factor of safety to the consumer lies with the fertilization rather than with the washing. The Epidemiological Aide of the State Board was requested last week to investigate these farmers to ascertain if a carrier or carriers worked in these places.

In the case of the Edgewood house where there was no sewerage, the health problem was solved on the rural sanitation basis. This section could easily have caused a fly-borne outbreak because of its open privy vaults. The contacts developing in this house were a discredit.

The outbreak in the upper part of the city was handled on the Chinese plan of adhering to cooked food. If one studies what is known of the Chinese and their habits of using human excrement for fertilizer, and this excrement is so valuable to them that it is peddled about in containers at the ends of their bamboo poles in the over populated agricultural districts, the wonder is why typhoid fever is so infrequent in China, for we know the Chinese are not immune to the disease. The answer is the Chinaman puts nothing into his belly until it is cooked. Travelers from foreign countries while sojourning in China are stricken often enough with typhoid to show us there is nothing in the soil of China or in the excrement of the Chinese to render the bacillus typhosus avirulent.

The contact case occurring in this outbreak is a splendid tribute to the work of the Registered Trained Nurse who managed this work for the City Board of Health. Many authorities admit from 6 to 65% in various places.

There are some general propositions to be considered in connection with typhoid from the public health viewpoint.

Every facility must be furnished the physician for the early diagnosis of this and every other disease. A properly equipped laboratory manned by a competent bacteriologist is a prerequisite, but physicians must make use of these facilities. Health officers receive these reports averagely after the patient is sick 18 to 20 days. All of you will admit this is a long time to make a diagnosis of the vast majority of typhoid fever cases and does not give the contacts a chance for earlier immunization. Any febrile condition of an indeterminate nature existing five days should be reported as suspicious of typhoid fever. Then instruction could be given the contacts and concurrent disinfection begun at once.

The more one studies the causes of communicable diseases, the more firmly he is convinced that man is man's worst enemy; that the nail brush is mightier than the tooth brush. The exceptions where the nail brush or tooth brush will not protect are generally known.

THE TREATMENT OF THYROTOXICOSIS.*

By THOMAS P. LLOYD, M.D.

This paper will deal exclusively with toxic goiter, especially in the young individual, in the early stages of this disease.

We believe that all cases of thyrotoxicosis are essentially medical in the beginning. There should be no competition between the surgeon and internist in the treatment of goiter. Certain cases are as distinctively surgical as others are medical. We must learn to differentiate between those belonging to each group, and to as nearly as possible standardize both classification and treatment, leaving to the surgeon:

1. All cases of enlarged thyroid for reduction for cosmetic purposes.
2. For relief from pressure.
3. Removal of malignant or benign tumors or cysts.
4. Cases of toxic goitre, complicated or not, with exophthalmos, when symptoms demand prompt action, ligation, lobectomy, etc.
5. Non-toxic adenomata.

This narrows the field of activity of the internist to the *toxic* type—*exophthalmic, hyperplastic, adenomata*—90% of which can be cured by methods other than surgical. This again adds to the surgical list about 10% of the toxic type.

Causes of Hyperthyroidism.

McCarrison's[1] classification of the causes of hyperthyroidism are simple, convenient and generally accepted, that is, *nutritional, toxic* and *psychic*. He claims that lack of vitamines leads to diminished thyroid secretion, and Mallanby has suggested treating Graves' disease by eliminating fat-soluble vitamines from the dietary. McGarrison conclusively proves, in his experiments on pigeons and tadpoles, that goitre can be produced at will, by diet. He concludes with the following remarks: "The result of the experiments indicate that there is such a thing as a fat-thyroid-iodine balance, and that this balance may be disturbed either by an intake of iodine insufficient for the needs of the body in the particular circumstances in which it finds itself, or by the presence in the digestive tract of an excess of free unsaturated oleic acid. Goitre may arise, therefore, either from an actual or relative deficiency of iodine. We thus have

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an example of a deficiency disease (goitre) due to an insufficient supply of the essential of the food (iodine) arising in consequence of, or favored in its development by, excess of another essential of the food."

It is generally conceded that general or local toxemia may cause goitre. The literature is full of authoritative evidence that oral and tonsillar infections are causative factors, as well as intestinal toxemia.

(Plummer) "That introduction of bacteria into the digestive tract is an important factor, if not the primary cause of endemic goitre, is fairly well established. As to how the organisms act in the host, there is no definite evidence. That the bacterial flora in the digestive tract may sufficiently interfere with the absorption of the small amount of iodine available in the diet is a possibility, particularly in areas in which this element is relatively small. The relation of the bacterial flora to the available iodine would explain the geographical distribution of goitre."

Phychic: W. Langton Brown [2] says that happy people do not get Graves disease. The factor of shock was shown repeatedly during the air raids on London and after the San Francisco earthquake. The emotions find their expression through the sympathetic nervous system, and it is the sympathetic that enervates the thyroid gland. Cannon's experiments on cats definitely proved that stimulation of the cervical sympathetic would cause exophthalmic goitre.

Considering that the causes of goitre are *nutritional, toxic* and *psychic,* it is necessary to treat thyrotoxicosis with the idea that any one or all of these factors are influencing the case under consideration. Surgery, X-rays, and radium all act the same way, that is, by diminishing the thyroid secretion, and are only indicated in well established cases, where definite pathological changes in the thyroid gland have occurred.

Again quoting W. Langton Brown: "Once the vicious circle is started, it is hard to break, for the sympathetic stimulates the thyroid, and thyroid secretion lowers the threshhold of sympathetic stimulation. Operation, X-rays or radium operate merely as factors in breaking this vicious circle by diminishing the amount of thyroid secretion and thus allowing the balance to be restored."

How are we going to treat these cases where little or no thyroid pathology is present, but altered physiology has become manifest by a symptom complex, more or less acute, or possibly with insidious onset? An early recognition of these cases will lessen the necessity for surgical treatment.

1. *If the cause be nutritional,* associated with intestinal toxemia, resulting in lessened iodine-bearing food assimilation, then the intestinal flora should be changed, iodine-bearing food given freely, using at the same time potasium iodide or syrup of the iodide of iron.

A. Loewy and H. Zondek, Deutsch Med. Wchnschr. 47:1387 Berlin, November 17, 1921[3]: "Iodine therapy serves to reduce this increased metabolism and catabolism so that the loss of weight is kept within narrow limits or is changed into a gain in weight. The dosage is very important; beginning with 3 drops three times daily, of a 5% potassium iodide solution, watching the body weight very closely. The dose is increased as long as the body weight keeps on increasing. The upper limit of tolerance is an individual variation and may be reached with 20 drops of potassium iodide solution in some cases." Quinine hydrobromide is said to have a sedative on the sympathetic, and is recommended by some observers.

2. *If the cause be toxic,* such as oral or tonsillar, these causes should be removed.

3. *If the cause be psychic,* the treatment should be adjusted accordingly. Psychotherapy skillfully used, with the patient placed in happy environment, removed from unhealthy mental hygienic conditions, will effect a cure.

Rest is a necessary adjunct and where possible should be insisted upon. Thyrotoxicosis has a tendency to spontaneous recovery, prolonged rest in bed will alone often bring about the desired result.

In the past few years our attention has been attracted more and more to the roentgenotherapy of the thyroid gland. Conflicting reports as to its efficacy are often seen, so with the idea in view of determining for ourselves the best course to pursue in certain cases of thyrotoxicosis, we selected 17 cases for X-ray therapy. Thirteen of these cases were of the early toxic type, with small but palpable and visible thyroid enlargement; one with decidedly enlarged gland of 10 years duration with marked

degree of exophthalmos, and one case of post-operative relapse. There were no borderline cases, all were frankly toxic goitres, presenting the usual classic syndrome. Seven of these cases are now clinically well, 6 are still under treatment and show marked improvement, and 3, out-of-town cases, have discontinued the treatment for unknown reasons.

Our roentgenologist, Dr. C. P. Rutledge, treated these patients, prescribing the dosage as he thought applicable to the individual case. We watched the progress of these patients with a great deal of interest, checking up their metabolism as occasion demanded. We can not now assert that all of these cases or any of them are permanently cured, because sufficient time has not elapsed, but we can say that not one of them has shown symptoms of recurrence. Then why is it not good practice to treat thyrotoxicosis with means other than surgical. We do not preach against surgery, but we do know that in such cases as above described the X-rays are wonderfully beneficial, and that in the hands of a competent administrator are safe and harmless.

At the Highland Clinic every case has the advantage of frequent consultations of surgeon, clinician and roentgenologist. We are all of one accord as to the ones surgical and medical. We are trying to standardize our methods of treatment and group our cases so that every one will secure the treatment best suited to his case.

Our special *thyroid chart* herewith attached, is modeled after the one used at the Massachusetts General Hospital.

HIGHLAND SANITARIUM
SPECIAL THYROID SHEET

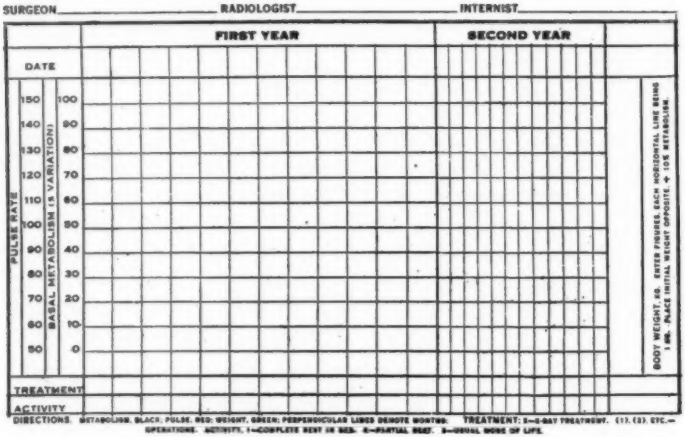
HOSP. NO.
O. P. C. NO.
MED. LAB. NO.

NAME _____ AGE

ADDRESS _____ DATE DIAG. MADE

DIAGNOSIS _____

SURGEON _____ RADIOLOGIST _____ INTERNIST _____



DESCRIPTION OF CASE, (Date

Duration of Goiter , of Toxic Symptoms

Degree of Hyperthyroidism judged clinically. Mild, Moderate, Severe.

Previous treatment.

Chief Symptoms. (Indicate intensity by 0, +, + +, or + + +).

Nervousness, Irritability, Sweating, Asthenia, Diarrhoea,
Dyspnoea, Palpitation, Appetite, Loss of weight, Cts.
Other,

Physical Signs.

Emaciation, Objective Nervousness, Exophthalmos,
Thyroid,
Tremor, Sweating, Tonsils,
Heart,
Mental State,

General Statement of Progress, Type and Severity of Disease.

Illustrating Thyroid Chart used by Dr. Lloyd.

PERIODS IN HOSPITAL

ENTRY DATE DISCHARGED DATE SERVICE
REENTRY "
REENTRY "

SURGICAL OPERATIONS

1	DATE	2	3
	OPERATOR		
	ANESTHETIC		
	OPERATION		
	RECOVERY		

X-RAY TREATMENT

	DATE	DOSE	AREA		DATE	DOSE	AREA
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

MEDICINAL TREATMENT (GIVE DATES)

COMPLICATIONS (GIVE DATES)

LARYNGOSCOPIC EXAM. (GIVE DATES)

BEFORE OPERATION
AFTER

PATHOLOGICAL REPORTS

SURGICAL PATH. REP. (DATE)

AUTOPSY (DATE) No.

FOLLOW-UP & END-RESULT DATA

DATE		DATE	

Illustrating Thyroid Chart used by Dr. Lloyd.

CASES PROBABLY CURED.

Case 1. Mrs. B. N., age 29.

History of goitre one year. Pulse rate 120.

Given three treatments, but owing to advanced pregnancy, treatments discontinued.

Patient seen several months since last treatment. Pulse rate 86. Cured of all subjective and objective symptoms.

Case 2. Mrs. C. A. M., age 24.

Goitre noticed 18 months before first treatment, which was given in April, 1920.

At time of treatment right lobe appeared to be about the size of a guinea egg, the left slightly smaller. Five treatments were given at monthly intervals. Patient then went away for summer vacation and did not return for observation for about five months, at which time no visible enlargement could be detected, her nervousness was entirely relieved, and pulse rate was 84. Patient was last seen about a month ago, and appears to still be in perfect health.

Case 3. Mrs. E. J., age 23.

Examined September, 1920, when there was a palpable enlargement about 2½ inches by 1 inch, of right lobe. Pulse rate 100, with the usual nervous phenomena. First treatment given at this time and thereafter at monthly intervals, including a total of eight; last treatment April, 1921. At that time there was still a noticeable enlargement of the right lobe, but very much decrease in its size, all nervous symptoms had disappeared, pulse rate was 80. The following month, while in the East, this patient was examined by Dr. Crile, who pronounced her cured. She has been seen lately by author and appears entirely well.

Case 4. Miss R. C., age 29.

First seen November, 1920. Pulse rate 130. Patient extremely nervous with marked exophthalmos and very noticeable enlargement of both lobes of thyroid, the right slightly larger than the left. Patient was given ten X-ray treatments at monthly intervals, at the Highland Clinic, and three treatments in Colorado, same technique being adhered to. The last treatment was given in November, 1921. Examination at that time showed a complete disappearance of thyroid enlargement and all nervous symptoms abated. Pulse rate 80 and no exophthalmos. Patient had gained 35 pounds in weight and appeared normal in all respects. This patient has been seen within the past few days, and still appears to be in the very best of health.

Case 5. Mrs. C. A. S., age 20.

First seen March, 1920. Gave history of slight enlargement of thyroid of two years' duration. Was extremely nervous and tired very easily on exertion. Pulse rate 120, weight 107. X-ray treatment instituted immediately, and given at monthly intervals, until a total of six treatments had been given. At this time patient had gained 22 pounds in weight and pulse rate was 80. She left promising to return should any aggravating symptoms reappear. Patient has not been heard from since, and we consider her cured.

Case 6. Miss G. T., age 19.

This patient was first seen in February, 1921. She had a marked enlargement of thyroid gland with the usual nervous symptoms. Pulse rate 120, and she was losing weight rapidly. Soon after examination patient was operated. She seemed to be benefited temporarily, pulse went down, and nervous symptoms were relieved to some extent. In May, 1921, she returned with practically the same

nervous manifestations as seen before operation, pulse rate 120, and further enlargement of the gland. X-ray treatment was given at this time, and at monthly intervals, until four treatments had been given, the last one in August, 1921. At this time the thyroid appeared normal to palpation, patient had gained about 30 pounds in weight, and pulse rate was 82. All nervous manifestations had subsided. Patient was dismissed and instructed to return for monthly observation, which she has done, being seen about a month ago, when condition was same as reported in August, 1921.

Case 7. Mrs. E. L. G., age 16.

First seen November, 1920. Noticeable enlargement of thyroid, pulse rate 110, weight 107. Patient showed usual nervous manifestations, being extremely nervous during menstrual periods. First treatment was given at this time, and at monthly intervals, until nine treatments had been given. Last treatment July, 1921, at which time patient weighed 122 pounds, all nervous symptoms had disappeared, and pulse rate was 76. Patient has not been seen since, but her father, who is a physician, reported a few days ago that she is doing fine.

In three of these cases the treatment was augmented by six weeks rest in bed.

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SOME OBSERVATIONS ON THE SCHICK TEST AND THE TOXIN-ANTITOXIN IMMUNIZATION IN THE CONTROL OF DIPHTHERIA.*

By W. H. SEEMANN, M.D., New Orleans.

The progress in the control of diphtheria has not universally kept pace with the reduction in the mortality from the disease. The mortality rate, which, before 1890 (when antitoxin was introduced), had been 64 per 100,000, has now dropped to an average of 15.3 per 100,000, a reduction of over 75%. The case rate has not appreciably changed during these thirty years, still averaging around 200 cases per 100,000 population per annum.

While it has been computed, that there have been saved, owing to antitoxin, over one million lives, during the past third of a century, yet there have occurred, during the same time, 300,000 deaths from diphtheria, not to speak of the immense loss in money and time, and the great suffering entailed.

It is obvious that any procedure which promised an amelioration of the conditions mentioned, would meet with a grateful and hearty response on the part of the medical profession and

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the public, so when, in 1913, the test devised by Schick to determine the potential resistance of individuals to diphtheria toxin was published, a hopeful enthusiasm encouraged the belief that an end to the diphtheria problem was in sight. The vista was made especially bright, in view of the toxin-antitoxin immunization suggested by Von Behring, and first used on pledgets of cotton, intranasally, and later subcutaneously injected. The results of his later work were also published in 1913 and were so encouraging as to prompt other workers, including, especially, Park in this country, to carry on investigations along the same lines.

Today there is a widespread use being made in a more or less systematized fashion, of the Schick test and the T. A. mixture for immunization and I had hoped to collect sufficient statistics to be of some value in asking from the profession a concerted movement to promote the more general and sytematized use of this procedure. I am convinced that any effort along the T. A. line, unless made general, will fall short of expectations, and may fail entirely to relieve conditions.

Schick has announced that if an individual has in his blood as much as one-thirtieth of a unit of diphtheria antitoxin per c. c. he would be immune to the action of diphtheria toxin and hence would give a negative reaction. Von Behring claimed that as little as 1-100 unit per c. c. will protect against any serious results in uncomplicated cases. The value of the Schick test is to determine whether natural immunity to diphtheria is present in the persons tested.

The technic of the test is very simple and with a little orderly arrangement and the assistance of a nurse, or other intelligent help, it is no great task to test a hundred or more individuals in a day. It has been found that the toxin which is used in the test must be freshly diluted in order to be sure that it is potent and be an accurate basis of determination. The amount of toxin required for each test is 1-50 m. l. d. for a 250 gram guinea pig, and is so diluted in bulk with normal saline, that this dosage will be represented by 1 c. c. This amount is recommended by Schick, and while 2 c. c. have been used by Park and others in this country there is a tendency to return to the smaller dilution which seems to prevent false negative reactions in slightly deteriorated toxin.

Under aseptic precautions and by means of a tuberculin or some such close fitting accurate syringe, 2 c. c. of the dilution of toxin is injected into the skin and not under it. A raised white area or small wheal will result if the injection has been properly administered, and is absolutely necessary as an indication of a proper technic. The small amount of toxin must remain in the skin long enough to exert its irritant action, otherwise the test is worthless, and the findings may be misleading.

Schick discovered that in older children or adults a certain protein reaction occurred which had nothing to do with the toxin's specific toxicity, so to properly read the results of the test another injection should be made in a similar manner and with the same quantities of materials, at the same time, with the exception that in the one case the toxin has been heated to 75° C. for 10 minutes to destroy its specific toxicity.

It is usual and very good practice to choose the flexor surfaces of the two forearms as the locations for the tests. It is best to have two syringes for the different solutions but if only one is available, of course, the heated toxin dilution must be used first. A positive reaction will show only on the side in which has been injected the specific unheated toxin. It will appear in 24 to 48 hours as a small area, averaging 1½ cm. in diameter, characterized by redness and skin infiltration. This persists from 5 to 14 days, gradually fading and leaving a brown pigmentation, and some slight desquamation.

The control reaction in the other arm will serve to act as a guide to determine whether the reactions are due to specific toxin, to protein reactions or whether they are combined reactions.

The chief rules with regard to these tests, as with many others, is to make them carefuly and uniformly. Only in this way can one check results.

Some six years ago I had the privilege of observing some of the first tests made on the children in the Willard Parker hospital in New York, by Dr. Park and his assistants, and brought back with me a considerable amount of test material. I secured the co-operation of Dr. H. P. Jones and together we performed the test on nearly one hundred children, in an orphan asylum, under the care of Dr. Jones. It is interesting to note that at that time we did not use the syringe method but used instead a small chisel like scarifier such as was used in the Von Pirquet

test for tuberculosis. This method of course was slow and cumbersome but our results were easily controlled and gave about the same rate of positive and negative findings as have been recently reported as the average.

These results tally with some more recent ones we have made in an asylum in New Orleans, in which in a group of approximately 75 children of ages from 2 to 19 years, we found 45.83% positive, 48.61% negative, and 5.55% doubtful.

In this group no negatives were found under 4 years; at 5 years, 13% were negative; at 6 years, 60% were negative; at 7 years, 66% negative; at 8 years and 9 years, the positives and negatives were equal, and above these ages the negatives increased. Above 16 years all were negative. Of course this is not usual. Park reports that he has found about 20% of adults to give a positive reaction. In a small group of medical students I have recently tested I found approximately one-fifth to give a positive result.

In the asylum group mentioned, it is interesting to note that one of the positive reactors who was given three full doses of the T. A. mixture subsequently developed a nasal condition, associated with fever and the presence of Klebs-Loeffler bacilli. Antitoxin was given and the case classed as diphtheria. This case developed about two months after the T. A. treatment, and it is worth calling attention to the fact that when immunizing it requires, in animals which have no trace of natural antitoxin, from 4 to 12 weeks before appreciable amounts develop and accumulate in the blood. This negatives the value of attempting active immunization in the face of an emergency, and calls attention to the fact that various human beings will react differently to stimuli introduced.

The case mentioned emphasizes the fact that the introduction of antitoxin even in large amounts, or the use of T. A. mixtures has no appreciable effect on the carrier possibilities of an individual. Park has found that many cases of negative reactors in the Willard Parker Hospital have become carriers of virulent diphtheria bacilli.

Attention might also be called to the fact that the mere existence of a tonsilitis in a negative reactor, with the presence of diphtheria bacilli, does not necessarily mean diphtheria. Eight

such cases occurred in Park's series during five years, and only two were given antitoxin. All recovered.

It must be remembered that antitoxin and T. A. mixture only tend to reduce mortality, and actual control of infection will depend yet on clinical and laboratory diagnosis of cases, and laboratory identification of apparently healthy carriers. Unless the use of T. A. immunization is general it will never accomplish its expected purpose; on the contrary it will take away the danger signals that would usually appear in the average individual who had become infected with virulent bacilli, and the usual danger signal, in the shape of the throat symptoms, would not be there to give warning.

A very excellent article by Cumming has emphasized some of these points. He emphasizes the fact that even if the 20,000,000 children of school age were immunized this would still leave 7000 deaths unaffected. It would require that 31,000,000 be immunized and this number be increased by 2,000,000 annually. His conclusions are that mass sanitary protection is best; that the control rests with the control of the carrier and the carrier routes.

DISCUSSION.

Dr. J. A. Lanford (New Orleans): I have very little to add to what Dr. Seemann has said further than to emphasize that point made that in the prevention of the spread of diphtheria, reliance should not be entirely placed in a negative Schick reaction, because an individual may be immune to diphtheria and yet harbor within his respiratory passages living diphtheria bacilli.

Therefore, in order that a person may not be a menace to the life and health of a community, and especially to those with whom he comes in contact, it is necessary to make cultures from the nose and throat of all individuals exposed to diphtheria infection.

This particularly is true in making surveys of institutions for the detection of carriers, for it is those who are carriers who may give a negative Schick test.

Dr. H. P. Jones (New Orleans): I have always been grateful to Dr. Seemann for giving me the material with which these tests were made in New Orleans. We used the intra-dermal method at that time, and if I recall, the children all had nose and throat cultures made within two or three days before the Schick test was applied. In that institution, while they had had an occasional case of diphtheria and scarlet fever, I do not recall a second case occurring from any infectious disease except measles and chicken pox. No case of scarlet fever and no case of diphtheria was traced to a case in that institution. The children range in age from three months to eighteen years, and as Dr. Seemann said, the results followed very closely what is to be expected in any community of children. I believe, through the foresight of Dr. Seemann, that these were probably the first series of Schick tests made in the South.

Dr. W. A. Dearman (Long Beach, Miss.): I think Dr. Seemann's paper is one of great importance, and should be given close study

by physicians who have to do with diphtheria. I think that I was the first physician to make the Schick test on the Gulf Coast.

I knew a health officer who asserted that he could take an ordinary syringe and successfully and accurately administer the test; but it should be borne in mind that the successful application of this test requires many details which are mostly quantitative: a potent toxin, the proper dilution, technique and correct interpretation of the reactions, comprise the fundamentals underlying its administration. At this time biological houses are not supplying the heated toxin which is essential and should always be administered as a control. It is very important that the reactions be correctly interpreted, and "pseudo" as well as doubtful reactions occur quite frequently.

For the past five years I have depended upon the Schick test in all cases of diphtheria coming under my observation and have not given a prophylactic dose of antidiphtheric serum to any contacts who gave a negative reaction. I have no confidence in any measure that has been set forth to prevent the possibility of anaphylactic shock in patients who have had a previous dose. I know one physician who lost two in one day from anaphylactic shock; these patients had been given prophylactic injections many months prior to the fatal issue.

I would warn against dismissing a test as negative when a zone of redness persists after forty-eight hours though not any larger than the size of the original wheal at time of injection. An individual must have 1/30 unit of antitoxin to every c.c. of blood in order to be immune to the disease.

We should bear in mind the clinical types of this disease, tonsillar, nasal, primary laryngeal and tracheo-bronchial as well as a few other clinical types. The mortality of 13 per cent could be materially lessened if the physician would recognize these cases early. No clinician can be positive from mere inspection in the differential diagnosis of the various anginas.

Dr. W. H. Seemann (closing): I do not want to go into the subject of anaphylaxis, but we must remember that immunity is relative. Conditions may occur in which the physical surroundings may reduce the natural or acquired immunity of individuals to such an extent that he may become susceptible to something to which he has previously been immune. One of the kings of France, Louis XIV, had an attack of smallpox in his youth and died from an attack of smallpox later on. If that can occur in variola, we may expect variations in other diseases. The Schick test must be controlled by subsequent Schick tests. The big point I want to bring out is the necessity of remembering that we cannot overthrow our old methods entirely for the new methods. I agree thoroughly with Dr. Dearman about the necessity of using accurate measurements and also about the advisability of being sure of your toxin.

THE RELATION OF GALL BLADDER DISEASE TO DIABETES.*

By ALLAN EUSTIS, M.D., New Orleans.

It is well known that after diabetes is established there is no cure and efforts are only palliative. McLeod and Banting in Toronto, with Insulin have a remedy which seems to control the disease.

Future progress in the study of the disease must be along lines of preventive medicine. Joslin and Paullin call attention to Obesity and Heredity as causes; Allen, excess of carbohydrates; H. Gideon Wells, Traumatic Diabetes with calcification. Very little has been written as to gall bladder disease being a factor in the causation of diabetes.

ANATOMY OF PANCREAS: ISLANDS OF LANGEHANS IN TAIL OF ORGAN.

Opie twelve years ago in "Diseases of Pancreas," mentions the relation of gall bladder to pancreas. Opie dissected duct of Wirsung in one hundred cases and found anatomy similar to accepted authors. Diverticulum of Vater: Its length, Testiel, 6-7 mm., Sappey, 7-8 mm. Opie states: "Occasionally the two ducts have no common channel, but open by separate orifices."

Proximity of common bile duct to head of Pancreas: "It descends alongside the head of the pancreas, occasionally embedded in its substance and comes in contact with duct of Wirsung, beside which it lies for a variable distance, before entering the wall of the intestine."

Little stress has been laid upon infection of gall bladder and common duct traveling to pancreas and causing inflammatory changes. I have been interested in alimentary glycosuria for past eleven years, and since 1911 I have records of 36 cases of alimentary glycosuria. Fifteen of these, or 41.6% have shown definite gall bladder disease during observation over a long period of time. Tenderness over gall bladder with dyspeptic symptoms may not be noticed at first examination. Six, or 16.6% have definite diabetes today, with hyperglycemia and other cardinal symptoms of the disease.

Treatment and diet aimed at sparing the liver has given better results than a low carbohydrate diet, and some have even become sugar free on a low protein diet.

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*Read before the Orleans Parish Medical Society Meeting, October 23, 1922.

CASE REPORTS. DIABETES.

Case 1. Mrs. W. C., first came under observation in 1915, when she consulted me for cough due to dilatation of heart and aorta following a grippal infection. Gall bladder drained in 1911 by Dr. Miller for gall stones. At this time (1915) there was no sugar in her urine and examination of her abdomen was negative except for a distended and tympanitic stomach. In 1916 there was slight yellow color to solerae and tenderness over gall bladder. No sugar in urine. November 11, 1917, a trace of sugar was first noticed in her urine. December 10, 1919, there was 1.6% sugar in urine, and she was complaining of pruritis. There was weakness and loss of weight. December 19, 1919, there was 3.5% sugar, and her weight was 165. February 21, 1921, 0.8%, 5.4 gms. 675 c.c. There was severe gall bladder colic two or three times. March 23, 1921, 0.6% sugar, 3.69 gms., weight, 156¾. May 11, 1922, fasting blood, 222 mg.

1 hr. after taking 107 gms. glucose .....363 mg.
2 hr. plus 107 gms. glucose.....400 mg.
3 hr. plus 107 gms. glucose.....370 mg.

In spite of sustained curve she has done better on a moderate low protein and moderate carbohydrate diet.

Case 2. Diabetes.

Dr. J. N. T., physician, 58, first seen November 25, 1918, with a severe myocarditis with dilatation of heart, pulsus alternans and dypsnoea. No sugar in urine. Chronic interstitial nephriits, albumin, weight 193. Gall stones in 1911, and gall bladder drained by Drs. Parham and Martin in 1911. Has been examined at frequent intervals. July 23, 1920, trace of sugar, liver enlarged and sensitive but no tenderness over gall bladder. On purgation and low protein diet, sugar promptly disappeared, weight 191¼.

December 9, 1920, 1.3% sugar in urine, marked tenderness over gall bladder, liver enormously enlarged, tenderness over region of pancreas, no jaundice. C. P. & R. low protein diet. Blood examined by Dr. Adams, not on fasting stomach, 256 mg. marked lipemia. December 15, 1920, after fasting, blood sugar, 168 mg. Lipemia less marked. At present, in about same condition.

Case 3. Chronic gall bladder and transient glycosuria.

P. R. P., 49 years old, first seen in 1912 and reported as a case of alimentary glycosuria in a previous paper. At that time had 7% of sugar in urine, no thirst or polyuria. Seen at irregular intervals since. Sugar found in urine by Dr. Ledbetter on insurance examination in 1914. First noticed soreness in abdomen, with belching, in 1917. Liver enlarged at this time, but no tenderness over gall bladder. Indigestion off and on, but no sugar in urine. In the summer of 1920, while traveling in the West, he had severe attack of vomiting with abdominal pains and chills and fever. September 21, 1920, mass in right iliac fossa. September 24, 1920, laparotomy by Dr. Allen. A ruptured appendix was removed. There was evidence of a chronic gall bladder and some little thickening of pancreas. Gall bladder not distended.

Case 4. Gall bladder disease. Operation.

Mrs. D. M., age 44, referred by Dr. E. M. Ellis for a glycosuria of two months' standing, which was intermittent and not associated with polydipsia, polyuria, or other cardinal symptoms of diabetes. Belching and indigestion. Physical examination negative except for marked tenderness over gall bladder. Inasmuch as her gastric symptoms predominated and the glycosuria was intermittent we decided to remove the gall bladder, which Dr. Ellis did under general anesthetic. At operation a chronic gall bladder was found with adhesions, which was removed. I understand from Dr. Ellis that since

operation she is able to partake of more carbohydrate food than formerly, but ingestion of sugar will cause glycosuria. It will be interesting to note the outcome of the case.

Case 5. Gall bladder disease, glycosuria.

A. T. C., student, age 23, referred by Dr. Spec Jones for glycosuria, polydipsia and polyuria at times, bad taste in mouth, headaches and vertigo. Tenderness over gall bladder with local rigidity of abdominal muscles in this region. Urine reduced Fehling's solution, but no action on polarized light.

Fasting blood sugar	90 mg.
One hour after taking 105 gms. glucose	85 mg.
Two hours after taking 105 gms. glucose	95 mg.
Three hours after taking 105 gms. glucose	89 mg.

My associate, Dr. Giles, in his report, says: "I feel that this patient just at present, must be classed as a case of renal glycosuria." On low protein diet after purgation, the urine did not reduce Fehling's solution, with a total excretion of only 1700 cc. in 24 hours.

CONCLUSIONS.

1. Transient glycosuria may be associated with a diseased gall bladder.
2. The glycosuria may exist before symptoms of gall bladder disease present themselves.
3. Such cases may progress to definite diabetes.
4. Treatment directed toward the diseased gall bladder may temporarily relieve the glycosuria.
5. In one case such treatment has relieved the glycosuria over a period of five years.
6. More systematic examinations of patients with glycosuria should be made, with the object of determining what percentage of glycosuria and true diabetes are associated with gall bladder disease.

DISCUSSION.

Dr. Daniel N. Silverman (New Orleans): The observations made by Dr. Eustis in his series of cases is of great interest to me. For the past two years nearly Prof. Denis and I have attempted to study the relationship between the pancreas and the infections existing in the biliary tract by means of analyses of the external secretion or enzymatic activity of the duodenal contents. Opie speaks of having found one case of glycosuria in thirty-five cases of chronic pancreatitis. In our series of eighty analyses there are about thirty cases with involvement of the gall bladder and liver. Without exception we have failed to demonstrate the presence of diabetes or of glycosuria in a single instance. There were many cases of chronic pancreatitis with the accompanying copious and fatty stools showing diminutions in the enzyme quantity. However, our failure to detect some of the transient glycosurias may have been due to less frequent examinations of the urine than those made by Dr. Eustis.

The association of abnormal pancreatic digestion with diabetes is

only occasional. According to Mosenthal, it is a rare incidence to find large and fatty stools even in very severe diabetics.

Dr. I. I. Lemann: I am sorry I did not have the pleasure of hearing Dr. Eustis' paper; I missed it and do not know just all of the points he brought out. However, he told me the other day of the contents of his paper.

This is an unusual experience in the observation of one man. We generally find things we are looking for and often we accumulate a lot of cases of one kind that seem to be unusual. It is hard to explain why one man sees a lot of cases another man does not. Gall stones, especially with glycosuria, are to be expected, and it is surprising that we have not seen more of it. I look upon Dr. Eustis' experience as that to be expected.

I do not know what interpretation Dr. Eustis has placed on the relation of gall bladder disease to glycosuria. It is apparent it can be explained in two ways. Gall bladder disease, with stones, occurring with blocking of duct will result with disease of pancreas. On the other hand, Naunyn believed that there was such a thing as true liver diabetes. The French school would have us believe that bile radicle disease is associated with gall duct and gall bladder disease. Observers after have not been able to confirm the idea of liver diabetes. In my own experience, the association of gall bladder disease with diabetes has been most uncommon. I have not had occasion to look over my own records but, from rough recollection, I recall only two cases where the association of gross lesions was suggested.

One was a man of about 50 years who had been brought here. Undoubtedly he had cirrhosis of liver, and there developed glycosuria. He was very decidedly jaundiced.

The other presented a very interesting history of long-continued indigestion with sudden collapse, suggesting perforated duodenal ulcer. He was an Englishman, in the East Indian service. The attack occurred in India. After a week or ten days he was somewhat better. He persuaded the authorities to put him on ship, and he finally got home. He developed a mass in epigastrium and from that developed fistula, from which was discharged a substance which irritated the skin. This mass was afterwards identified as a pancreatic cyst.

Later he developed phenomena of diabetes. He lost weight, experienced great hunger and thirst. When he related this phenomena to a friend he was persuaded to have his urine examined. He had a case of diabetes mellitus, apparently associated with a gross lesion of the pancreas.

Dr. D. Urban Maes: It seems to me Dr. Eustis has opened up a subject which should be discussed at length.

A good many years ago, when we began observing biliary disease this condition then was termed gall stone disease. The classical work from the German literature, especially langbuch, who made presence of sugar in urine a diagnostic sign of gall stone disease. Twenty per cent of the cases had it. To those who have grown up with biliary disease we are no longer speaking of gall stone but gall bladder disease, reserving the former term for such cases as show stone at operation.

I think Dr. Eustis' paper is interesting, however I must agree with Dr. Lemann.

I regret very much that stress has been laid upon the anatomy. I do not believe that we are justified in believing that damming of bile or the mechanical obstruction of stones, has anything to do with the presence of sugar in the urine. This has been worked out experimentally by a great many, mostly by those at the Rochester

clinic, Deaver, Archbald and others. A common opening of the common bile and pancreatic ducts occurred in less than thirty per cent of the cases. In those cases where there was damming back of bile a local reaction with necrosis may occur but was not a causative factor in diabetes.

Observations of Archibald, Judd and Deaver have all demonstrated the intimate connection of lymphatics, gall bladder, bile duct region and the pancreas.

If there is pancreatic disease superimposed on gall bladder disease it must be of lymphatic origin. This is a reason for the plea some of the surgeons to make for removal of the gall bladder, that is, on account of the connection of the lymphatics of the bile passages and pancreas. If we leave in the gall bladder we may be inviting diabetes, whereas, if the gall bladder is removed the risk of subsequent pancreatitis is certainly minimized.

Dr. Allan Eustis (closing): I appreciate your liberal discussion.

I have a point I want to call to your attention. Dr. Giles mentioned jaundice as evidence of gall bladder disease. In the majority of cases of gall bladder disease (presented) there is no history of jaundice. These cases were presented with that in view.

My experience with pancreatitis has been different from that of Dr. Silverman's. Every case of pancreatitis I have had has shown history of glycosuria. As an example, there was a doctor from Illinois treating himself (?) for diabetes. He had chronic pancreatitis. When I saw him he had no glycosuria at all. He had had sugar before. The only way we will take care of the matter is by proper examination.

I believe I see more alimentary or transient cases than any one in town. Every time I see a case the urine is examined.

This applies also to the gall bladder. I first believed in Naunyn's group. I believed there was something in true hepatic gall bladder disease. I might say that one of these cases did not show tenderness over the gall bladder. Dr. Lemann has undoubtedly overlooked many cases of gall bladder disease in his diabetics, as one of my cases had passed through his hands. His symptoms were essentially dyspeptic.

I want to set myself straight on the mechanics. I did not claim that blocking would cause glycosuria. I laid stress on the fact that infection from the common duct can travel through and make pancreatitis.

Dr. Maes: Gall bladder disease with infection could exist with no symptoms. I might say that the X-ray helps in arriving at a diagnosis of gall bladder disease.

Dr. Allan Eustis: I have one other point to make. I was not laying stress on gall bladder disease with diabetes, but of glycosuria.

Of thirty-six cases of transient glycosuria and gall bladder disease, six cases developed diabetes under my care.

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EDITORIALS.

THE STATE SOCIETY.

At New Orleans, on April 10, 11 and 12, will take place the next annual meeting of the Louisiana State Medical Society. Elsewhere in the Journal will be found a list of committees. The prospects for a banner meeting are unusually good. The scientific and economic value as well as the joy of "rubbing elbows" with the other fellow make their own appeal to the individual. Therefore give in to the impulse and come to New Orleans. Incidentally, instruct your delegates as to your wishes in regard to YOUR Journal.

The present editorial staff feel that they are after a fashion temporarily "filling a gap" in getting out the Journal as best they can under the existing circumstances and until such time as adequate provision can be made by the House of Delegates for a stable, permanent organization and equipment. Upon the decision of the House of Delegates will depend the future of the Journal. Shall it be mediocre or a greater, bigger journal, truly representative of the State Society? How shall your delegate vote? *If you have an opinion on the subject, speak through your delegate!*

MEDICINAL WHISKEY.

There are perhaps no two other commodities so readily subject to substitution as are drugs and alcoholic beverages. In the hands of the unscrupulous the possibilities for charlatanism are enormous. As regards whiskey the better class of drug stores have already anticipated the law and have dispensed from the beginning only whiskey bottled in bond. This, however, has not been by any means the universal practice. In the future physicians prescribing whiskey can do so with greater assurance that their patients will not receive spurious or detrimental substitutes. This protection will result from a recent decision by the Commissioner of Internal Revenue. According to this ruling, bottled in bond whiskey for medicinal purposes will soon entirely replace bulk whiskey.

ABUSE OF FREE MEDICINE.

Like Banquo's ghost, discussions on hospital abuse "will not down." Just recently, Dr. H. W. Kostmayer, in his presidential address before the Orleans Parish Medical Society, took this subject for his text and in the course of his remarks pledged himself to get behind a movement to thresh out the matter. If conditions are actually such as many of our medical confreres picture them to us, then surely the time has arrived when concerted action should be taken to stem the tide.

Our profession has ever displayed a most lethargic attitude towards this evil. Just why this should be, it is hard to fathom.

The time has arrived to speak plainly. It behooves us now to protect ourselves from any form of fraud and we should not permit the undeserving to share the same privileges for gratuitous medical service that we so cheerfully tender the deserving poor.

Repeatedly it has been stated by staff members who attend the out-patient department of Charity Hospital that property owners present themselves for treatment along with indigents and that many of them drive up to the clinic in their private automobiles. Surely such flagrant abuse of charity deserves our condemnation in no uncertain terms. Efforts should be made to abate this state of affairs. Reform can come only from within. We need not look to the lay public for a remedy. The Lord helps those who help themselves.

THE LOUISIANA STATE MEDICAL SOCIETY

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SOCIETY PROCEEDINGS.

PROCEEDINGS OF THE HOTEL DIEU STAFF.

Monthly Meeting for January, 1923.
The President, Dr. Homer Dupuy, in the Chair.

FRACTURE OF FEMUR.

Dr. A. C. King reported a case of intracapsular fracture of the femur. The patient sustained a fracture of the left femoral neck. Immediate X-ray showed this to be an intracapsular fracture near the great trochanter with considerable upward displacement of the shaft, producing a shortening of one and a half inches. A Hodgen splint was applied for 10 days. The long extension method was considered as were also a more direct treatment by fixation of the fracture by nail, screw or bone graft.

Dr. E. D. Martin suggested using ordinary iron screws inserted in such manner as to give absolute, permanent fixation. Dr. Martin had used this method with good results, though the case was not a particularly favorable one since the fracture was of several weeks duration.

Dr. King used the X-Ray plate as a measure and three-inch screws were selected as fitting the case, judging by the measure of the opposite femoral neck. The screws were demonstrated in the film as being slender and ordinary iron screws used by carpenters. They were not plated, but were clean and bright. Dr. King said that screws did not rust in bone as in the open air or in water. They turned black but did not rust.

The film was the guide as to the direction in which the screws should travel. An incision 4½ or 5 inches long was made directly over the trochanter going directly down to bone. As soon as the bone was reached one index finger was passed over the great trachanter between the muscular tendons and the seat of fracture found. As the fracture was intracapsular this procedure could do no harm. The assistant holding the leg was now instructed to make traction downward until both limbs were equal in length. While in this position a hole was drilled just below the trachanter through the hard bone and a screw inserted and driven in as hard as possible with the screwdriver, making sure that the

head must jamb up to bone. It was not possible to force a screw too tightly in bone. The tighter the better, as the job was permanent. A second drill hole was now made a little lower and at such angle as to leave sufficient space between the screws as well as to penetrate the bony head. An error was made here in failing to do just this thing, the point instead passing through the outer surface of the head, giving an insufficient hold. This was shown in a film taken immediately after completing the operation. No correction was made as the wound had been sutured, dressings applied and the patient partially recovered.

The limb was now placed in a Thomas splint and swung clear of the bed by means of a Lyle frame. No extension was required. The patient was quite comfortable after getting herself adjusted to the bed and apparatus and complained only of having to lie on her back. Union of the wound was primary.

The location of the lower screw not being satisfactory, it was removed and another was inserted at a little different angle so that the point would enter the bony head, giving a firmer grip. This was done 30 days after the first operation under local anaesthetic, the greatest difficulty being to locate the head and back the screw out. The final result was shown in plate three. There was absolutely no shortening. The patient was now walking with only a stick for support, and while a little stiff would soon limber up.

Dr. King had two more cases in the Charity Hospital. One elderly patient infected her own wound and died of sepsis. Physically this was an unsatisfactory case. The other case was a colored woman of 62, in good condition, who was now just ready to return home. The X-ray showed splendid position of both screws; no infection occurred in the wound and from the time of operation this patient had been wonderfully comfortable. Dr. King's experience was limited to these four cases. The operation was not intended to apply to aged patients nor impacted fractures in such patients, but certainly looked entirely suitable in young and middle age subjects. If possible, X-ray should be made immediately after placing both screws, and any errors corrected before the patient left the table.

Dr. Danna stated that he had had good results with Buck's Extension. He believed that the best results followed the use of Hodgen's splint. This splint would give as good extension

Illustrating Dr. King's Case.

Illustrating Dr. King's Case.

with the knee in position of flexion and the femur in position of rest as you could possibly get with any apparatus. He thought Dr. King's case was a perfect result as far as shortening was concerned as shown by X-ray.

He recalled a patient from Charity Hospital in a Jones' splint. She seemed to be very comfortable for transportation. Dr. Danna put her in a Hodgen's splint and for the last two weeks of treatment he put on Buck's extension, obtaining a perfect result. He could recall four or five such cases walking around perfectly well.

The Hodgen's splint had one great advantage in that the patient was able to move around comfortably in bed. Well applied and well watched he thought this splint gave the best results.

Dr. Nix felt that a mortality of twenty-five per cent was as low as one could expect in handling such cases. From an inch to an inch and a half shortening of the limb was to be expected. He cited Whitman's results with traction, wherein the simple pulling on the capsule of the joint approximated broken fragments.

Dr. Salatich remarked that, by means of a small drill, the introduction of nails and screws would be facilitated.

Dr. Cassegrain stated that in the work he had done in association with Dr. Gessner the drill was used to make holes, but instead of steel screws, bone pegs were used successfully.

Dr. Jerome Landry desired to know of Dr. King if any trouble presented itself in removal of such screws.

Dr. King answered that there was little trouble in removing them. The difficulty was in finding them as they soon became covered over with scar.

Dr. Walet felt that this procedure could not be considered applicable to very old patients. Here simple reduction was done as best it could, then application of plaster cast, and careful attention otherwise, was best.

Dr. King stated that the method was not intended for the very old patient for in the aged, Buck's extension was more suitable. He stated that he considered the Thomas splint superior to the

Hodgen's. In northern climates plaster casts might be tolerated but here, in the summer time, they were not welcomed by patients.

BREAST CANCER IN THE MALE.

Dr. J. T. Nix reported a case of breast cancer in a man.

Mr. J. J., a white male, aged 64 years, married, a native of New Orleans and an electrician by trade.

He consulted Dr. Nix November 22, 1922, and complained of a sore on the right breast and lumps in the right armpit but especially of pains in the right armpit while using his arm.

Briefly the facts of the case were as follows:

One year ago he had boils in the right knee and he thought that the lumps in the armpits were boils. He did not know the connection between the breast and the enlarged glands in the axilla. It was only the pain which he suffered while using the arm that made him seek medical advice. This pain was severe enough to interfere a great deal with his rest at night for three months. The glands were first noticed about six months ago. There was no history of trauma. Past history did not reveal anything of importance. He was married and had six healthy children. His wife had one miscarriage.

Family history: There was no malignancy in the family.

Physical examination: Emaciated tall white male. Weight 132½ pounds; 145 pounds his usual weight. The skin of the back of his hands showed many spots of keratosis senilis. The eye, ear, nose and throat examinations were negative. The thyroid was negative. The teeth were artificial. The heart was negative. Blood pressure S. 165, D. 90. The lungs had murmuring, sonorous rales scattered through the back. The examination of the abdomen was negative. On the right breast was a foul and ulcerated area about the size of a silver dollar, which had destroyed the nipple. The surrounding skin was infiltrated as was also the great pectoral muscle.

The right axilla was filled with glands, some of which were ulcerated.

The epitrochlears were enlarged.

LABORATORY EXAMINATIONS.

Fluoroscopy of chest: There were numerous areas of infiltration, some linear, others fuzzy. The breast and aorta were normal. The Wasserman reaction was negative. Total white count 8,500 per C. MM. Lymphocytes: Small 27, large 8. Neutrophiles 64, eosmophiles 1, hemoglobin 80. Urine: no albumin, sugar acetone nor indican. Phenol-sulphone-phthalein test: 50 C. C. 60%. Vital capacity test, 2.

Dr. Nix thought that perhaps every one present had seen one or two cases.

DaCosta saw three cases in ten years.

Warfield (Bull. Johns Hopkins Hospital, October, 1901) collected 32 cases from the literature and added 5 others.

Palenno (Semaire Medicale, May 20, 1908) collected 750 cases of tumor of the male breast and 649 of them were cancerous.

Sistrunk (collected papers of the Mayo Clinic, 1921), in a study of 246 patients with cancer of breast, did not have one case in a male.

J. J. Buchanan (Penn. Medical Journal, July, 1918), in a study of end results in 204 amputations done over three years, had two males in the series, both of whom died.

Matas and John M. T. Finney (Keen's Surgery) say that slightly over 1% of cancers of breasts occur in the male.

Delafield and Prudden, in their Text-book of Pathology, say that carcinoma of male breast forms about 2% of all mammary carcinomata.

Dr. Nix felt that the important question was the *treatment* of cancer of the breast.

Dr. Nix said that in early cases the treatment was simple and radical methods would be curative. In more advanced cases surgery in conjunction with radium and deep X-ray therapy should be used. When there were glands in the axilla the chances of cure were slight and when there were Metastasis in the lungs or other organs, the chances to cure were nil.

In the hopeless, far advanced cases, the palliative aid of radium and the X-rays was a great boon.

It was quite possible that in the future when radium and X-rays were better known the treatment would be principally non-surgical. Until that time came it was generally conceded that the treatment of malignancy today should be, 1st, preliminary radiation; 2d, surgery, when possible, excising disease tissue, and 3d, post surgical radiation.

Dr. Salatich stated he had operated but one male breast, but for a benign tumor, with uneventful result.

Dr. Jerome Landry emphasized the fact that up to puberty, the anatomy of the male breast is practically the same as the female. All lumps in male breasts should be treated the same as similar conditions in females. One per cent of these tumors were met with in males. Two per cent. of these tumors were carcinoma. He had no success with deep therapy. In a patient in which it had been tried death followed shortly after its use.

Dr. Maurice Gelpi could not recall a single case of carcinoma of the male breast, but he had seen two of sarcoma. He felt that we had some encouragement in deep therapy results so far. He had seen a recurrence in a case three years after radical operation. In this instance he excised the scar with the cautery and then applied a hundred milligrams of radium; he then excised a larger area and re-applied the radium, with but little success. He remarked that he was ready to give up. As a last

resort deep therapy was instituted six months ago and at the present time, all recurrence seemed apparently arrested.

Dr. Perret was optimistic over the treatment of these cases with X-ray and radium. His experience covered three cases, two operated, of which one died. An early carcinoma of the breast had but one treatment with radium, then discontinued treatment. Simpson claimed three out of five cures with X-ray and radium.

Dr. Fortier stated that in dealing with a growth as deadly as carcinoma no one must pin faith on any one agent alone. Severe, inoperable cases unquestionably should receive radium, X-ray and deep therapy. Radium should first be applied. This "localizes" the condition and blocks lymphatics. The glands were then treated with deep therapy or X-ray, whatever was available. Then removal of encysted mass would probably cure some of the cases.

Dr. H. E. Nelson stated the first case of cancer in the male breast he observed in 1910, while an interne in the Charity Hospital.

The patient, a colored man, gave a history of wearing a loose jumper, in the left pocket of which he carried a heavy watch. As he was a plantation overseer and rode horseback frequently, this caused a moving up and down of the watch against the left breast thereby causing friction. In due time there appeared in this breast a lump. When he presented himself for treatment the breast lesion was well advanced and unmistakably carcinoma. The patient refused operation and left the hospital, the case no doubt going to a fatal termination.

The next case was that of a white male that came under Dr. Nelson's observation in 1917. Dr. Nelson examined him at this time for life insurance. He gave a history of having had a breast amputation for cancer in 1914. The operation was a radical one; the pectoral muscles were well cleared out on that side. The pathological report at that time was that of cancer. This patient was living today and presented no evidence of recurrence.

Dr. Nix, in closing, stated that his case appeared hopeless to him. After deep therapy the mass went down in a striking manner.

PROCEEDINGS OF THE TOURO INFIRMARY STAFF.

Monthly Meeting for January, 1923.
The President, Dr. M. Feingold, in the Chair.

LUETIC BLINDNESS.

Dr. Weil presented a case illustrating the close relationship of ophthalmology with otolaryngology.

This patient first came to the clinic several months ago. The record was misplaced and he recited part of the history from memory. When he came to the clinic he complained of severe headache,—nothing else. Examination at that time showed the nose to be negative to all ordinary examination, but in the naso-pharynx there was evidence of some new growth in the right roof of the naso-pharynx. This was a tumor mass, rather diffuse, about the size of a large hazel nut with ulcerated surfaces, the whole appearance suggesting lues. The patient gave a definite history of leutic infection several months before, but the Wassermann was negative. On account of the constant headaches, an X-ray was made of the sinuses of the nose and the report came back that there was a distinct opacity of the sphenoid and ethmoid sinuses on both sides but somewhat more marked on the left. In the absence of any definite evidence of suppuration, the possibility of some form of hyperplastic sphenoethmoiditis was considered. but on account of the definite leutic history, and the appearance of the tumor in the naso-pharynx, it was decided to put him temporarily on mixed treatment.

Shortly after mixed treatment was begun his wife telephoned that suddenly during the night, without any warning whatever, the patient had completely lost sight in the left eye. Even light perception was gone. He was immediately admitted to the hospital. So much had been said on the subject of hyperplastic sphenoiditis and its effect on the optic nerve that it seemed at once that here was one of those cases, not at all uncommon, of blindness due to hyperplastic spheno-ethmoiditis with resulting pressure on the optic nerve. The inclination was naturally to do an exenteration of these sinuses without delay for the earlier such an operation is done the better the prognosis. The longer the delay the worse the outlook. The distinct leutic history,

however, and the appearance in the naso-pharynx still suggested the possibility of leus as a cause. Before anything definite was done, however, in a surgical way, it was deemed best to have the opinion of the ophthalmologist and neurologist, and Drs. Feingold and Holbrook examined the case.

The neurologist found evidence to suggest some intracranial tumor and the ophthalmologist found evidence of some growth in the apex of the orbit. This man became blind shortly after the beginning of mixed treatment, and it was just possible that this blindness might have been some form of Herxheimer reaction. This, however, did not seem probable because he had had only mixed treatment in moderate quantities and no salvarsan, which is much more apt to give the Herxheimer reaction than the mercury and iodides.

Dr. Feingold suggested, in spite of Dr. Weil's strong inclination to do immediate spheno-ethmoid exenteration, that on mercury rubs and iodide should be tried first. The patient was kept at rest in bed and treatment begun in the hospital.

He was kept in the hospital two or three weeks, showing much improvement, and was then sent home and treatment continued at home. His sight had improved very remarkably. He had no vision whatever at first and barely light perception, if any. Now the vision had improved so that he has 5/12 plus vision. Dr. Weil's inclination when he showed the marked improvements on mercury and iodides, was to institute more energetic treatment with salvarsan. Dr. Feingold suggested, however, that mixed treatment be continued.

In addition to the loss of sight, he had severe headache on the left side, the typical lower half headache as described by Sluder in these cases of hyperplastic ethmoiditis. The X-ray picture would likewise bear out the diagnosis of sphenoidal involvement. It was interesting to note, however, that the headaches had practically subsided since the anti-syphilitic treatment had been carried out.

From the findings the most plausible explanation was that he had a syphilitic condition of the spheno-ethmoidal sinuses extending down into the naso-pharynx. This theory was borne out by the fact that he had improved so consistently under anti-specific treatment.

Dr. Holbrook examined Dr. Weil's patient a few minutes after he was admitted to the hospital. For some time past he had been complaining of very severe headaches. Within twenty-four or thirty-six hours of coming into the hospital he had lost his sight in his left eye. Going into the history, he found that the patient admitted a venereal infection which was very suspicious of syphilis.

Examination showed that the patient was just able to perceive light when the electric torch was held close to his affected eye. After determining that there were no cooked discs present, spinal puncture was done. The fluid was under considerable pressure, was clear and examination did not reveal any marked changes. The cells were normal in number, the globulin was not increased, the Wassermann was negative and the colloidal gold showed very slight reduction.

He thought that the improvement that had taken place in this patient's sight had been very marked, but in spite of the fact that this improvement had apparenly taken place under the influence of anti-syphilitic treatment, he believed that one would have to delay judgment for several months in order to determine whether syphilis was really at the bottom of this man's trouble. One often saw improvement for a time under mixed treatment and then the condition grew worse. This was especially observed in tumors of the brain. It would be very interesting to watch Dr. Weil's case and we trusted it would continue to improve and that the tumor in his pharynx would disappear.

Dr. Feingold examined Dr. Weil's patient on his clinic days, Tuesday, Thursday and Saturday. On the first day, some slight light perception was recorded as well as sluggish pupillary reaction; the next examination showed no light perception, no reaction of pupil, either direct or indirect, very slight exophthalmos of the affected eye—two millimeters at most; in addition, there was a weakness of the external rectus. In spite of all this, the optic nerve was perfectly normal. Though his previous leutic history and pharynx condition was at first not known, the conclusion was that there was something interfering with the ciliary nerves because the pupil did not react, and at the same time with the abducens. This "something," it was thought, must have been pushing the eyeball forward, producing the exophthalmos and, because the disc was absolutely normal, this "something"

had to be at least one centimeter behind the eyeball because the vessels enter the optic nerve about 12 mm. behind the eyeball. Therefore, all the disturbance had to be at a point near the apex of the orbit. The fundus and field of the other eye were entirely negative; that excluded an affection of the chiasm or behind it.

Dr. Feingold thought the further developments interesting because for about a week after the treatment was started the patient could see absolutely nothing; but after that, suddenly light perception returned, then hand movements were perceived and he could recognize at a distance of one foot the characters which should be seen in 200 feet. From then on, his vision improved by leaps and bounds from day to day.

When examined six days ago, he had 5/12 vision. Three days ago was first noticed a peculiar halting, hesitating in his reading though his vision was still 5/12. Yesterday that halting, hesitating was a good deal more marked and the optic nerve, which had appeared normal all along, appeared somewhat pale for the first time. Whether it was the antileutic treatment that relieved disturbance and thereby re-established conduction and better vision which subsequenly became worse because of secondary atrophy, could not be said. The case was not finished by any means.

Dr. H. N. Blum found this man in his clinic one day and Dr. Howell had made a notation of a previous visit at which time vision was found to be 5/16. Not knowing he was in Dr. Feingold's service, we examined him and found what he considered to be a slight hyperemic condition of the optic nerve of one eye as compared to the appearance of the other optic nerve. In conjunction with a report from the radiologist, that there was an opacity in the sphenoid and ethmoid cells, he immediately thought of a retrobulbar neuritis due to sinus infection, and walked to the ear, nose and throat clinic to consult Dr. Weil about it. He was informed that he was Dr. Feingold's patient and was told the latter's diagnosis. There was then no exophtholmos and the diagnosis of retrobulbar neuritis was the most probable diagnosis. Dr. Blum said that in borderline cases it was difficult to decide whether or not a neuritis was present, and several examinations were necessary to determine definitely if inflammation was there.

Dr. Lynch asked if the sixth nerve paralysis was still present. It might possibly be due to one of the mixed tumors which grow

in the sphenoidal fissure and present themselves in the nasal pharynx posterior to the eustachian tube. It would be possible for such a tumor to make pressure on the sixth nerve in its progress through the orifice and in this way produce the paralysis.

These mixed tumors were of a semi-malignant nature and grew rather slowly but progressively and could be easily mistaken for gumma or the glands of Hodgkin's disease. It would seem that the mass on the opposite side of the vault of the pharynx would be syphilitic in character since it was reduced by the use of the syphilitic treatment. He was inclined to believe that the dose givien was rather small and would suggest the addition of iodide of potash.

Dr. Feingold said that the exophthalmos and weakness of the external rectus were gone.

Dr. Kearney asked if sections from the tumor could be obtained. If it was malignant he doubted if removal of a tissue specimen would be particularly harmful to the patient and might shed some light on the diagnosis.

During the past year he had under observation a patient with carcinoma which originated apparently in the nasopharynx in the left fossa of Rosenmuller. In this case, however, while the man had some auditory disturbance due to pressure on the eustachian tube and some respiratory disturbance due to obstruction of the nose, he had no visual disturbance.

Dr. Feingold said that this man's psyche has greatly changed. He was so hesitating, so diffident. He has become more normal.

Dr. Weil said that Dr. Lynch's suggestion that this might be a mixed tumor coming down from the sphenoid into the nasopharynx was worth considering, but the fact that the tumor in the naso-pharynx was on the left side whereas the blindness was on the right side, would speak against this theory.

As regards the abducens paralysis, it must be remembered that the sphenoid and posterior ethmoid cells lie sometimes in relation to the motor oculi nerve, the trochlear, the ophthalmic division of the fifth nerve, the maxillary division of the fifth nerve, and sometimes even the mandibular or third division of the fifth nerve, and the abducens or sixth nerve and that disease in this region by its effect on the abducens nerve could very easily account for the abducens paralysis described by Dr. Feingold. He was inclined to think that this was a leutic infection of the sphenoid and possibly of the ethmoid. It was true that the tumor

under treatment should diminish to a greater extent and on account of this he was anxious to have the patient treated with a few doses of salvarsan. Because if salvarsan was given this man and the tumor persisted, that tumor was not specific.

Dr. Feingold said that if the condition were a gumma, he did not see how mercury and iodide of potash would have less effect than salvarsan. Salvarsan, with its fleeting stay in the system, could not affect a gumma so easily as did mercury and iodides. Salvarsan could easily affect secondary lues but not tertiary. The lack of vascularization of a gumma would make it less influenced by salvarsan, while the greatly vascularized so-called secondary lesions ought to be affected easily by salvarsan.

Dr. Weil thought that in the ordinary conditions there was a miraculous improvement. He had seen them clear up tremendously with the use of salvarsan.

Dr. Lanford suggested that primary and secondary syphilitic lesions were purely local and were largely located on epithelial structures and not deeply in the tissues, so that they could be reached by medication through the circulation, but when gummata were considered and other tertiary lesions, the histological pictures showed areas of necrosis caused by shutting off the blood supply to the parts. Then something which was more slow and diffusable and lasting had to be given. That was why gummata improved under mixed treatment rather than under salvarsan.

Dr. Weil asked what inference was drawn from the fact that he was beginning to show an optic atrophy.

Dr. Feingold answered that some of the vision might be lost, but that he would retain some.

Dr. Hirsch had a case that brought out the fact that salvarsan had very little effect on some gummata. This was a case of gumma of the tongue that had been given twelve salvarsans in Hot Springs and when the condition did not improve, a diagnosis of malignancy of the tongue was made. When the case came to Dr. Hirsch it appeared to be a specific condition owing to the irregular distribution of the lesions. He had Dr. Lanford see this case in consultation and he confirmed the opinion. With mixed treatment and inunctions of 40% calomel ointment to the tongue, it was remarkable how quickly this condition improved.

PROCEEDINGS OF THE T. E. SCHUMPERT MEMORIAL STAFF.

Monthly Meeting for January, 1923.
The President, Dr. J. C. Willis, Sr., in the Chair.

ASCITES.

Dr. J. E. Knighton reported a case of acute abdominal ascites with rapid re-accumulation of fluid due to a mitral stenosis and resulting decompensation.

History: White female, age 45. Family and past history negative. Excellent health except for some shortness of breath until three weeks ago, when without warning, her mouth filled with bright red blood; she spat up about one pint of blood within an hour. One week later she had similar hemorrhage; repeated again another week. She was put to bed following the first hemorrhage. On being admitted to the hospital about two gallons of fluid were removed from the abdominal cavity.

Physical examination: Heart moderately enlarged but more to the right; musical presystolic murmur with thrill head over whole of the right; musical presystolic murmur with thrill heard over whole of precordium. Venous pulsation on the right side of neck. Soft sys- larged and tender; withdrawal of about five gallons of fluid in two weeks' time with rapid re-accumulation.

Dr. W. S. Kerlin called attention to the fact that the heart lesions and rapid re-accumulation were the most common courses of abdominal ascites.

Drs. R. M. Penick and J. C. Willis, Jr., reported a case of fibrous union of tibia and fibula of 1½ years' duration, cured finally by a sliding bone graft, 6 inches in length, after wiring with kangaroo tendon had failed.

FIBROUS UNION.

Dr. L. C. Spencer stated that the question of non-union of the tibia was a very important one and that the most common cause for non-union was syphilis, though there was a negative Wassermann in this case. That non-union was only presumptive evidence and that negative Wasserman was not sufficient. He further stated that to perfect immobilization was conducive to non-union and that slight motion was concerned in the proper nutrition of bone.

Dr.J. C. Willis, Jr., stated that in his opinion there were only two conditions where Lane plates were indicated, namely, following compound fractures with much displacement, in which

it was reasonably certain that infection had or would take place. Secondly, during an open operation, where it was found impossible to approximate and keep in position the ends of the fractured bones.

Dr. Penick stated that he had obtained excellent results with Lane splints, but that autogenous grafts were better.

HYSTERO-EPILEPSY.

Dr. J. D. Young reported a case of hystero-epilepsy or conversion neurosis.

A young white female, age 19, had been having convulsions for the past five months. Physical examination was negative. Neurological: Areas of anaesthesia over body not conforming to segmental distribution. Conjunctival, corneal and pharyngeal reflexes absent. Deep reflexes of both extremities exaggerated. No Babinski appenhern or Gordon. Abdominal reflex present. Narrowing of visual field.

Mental status: Stream of thought retarded. Speech jerky and rapid. Hallucination and delusions during convulsions, calling out "Let me kill him." "'There he goes." "Oh, don't let him get me." Amnesia of about 12 hours' duration after convulsions.

History: Convulsions began after trial by court of young man who shot her father. Patient was implicated in trial. After trial family blamed her as chief cause of shooting affray.

Upon talking matters over with patient she at first denied any love affair with the young man who did the shooting. After hearing her talk and rave in the convulsions Dr. Young felt positive she was not honest in the denial. With association tests and analysis of one dream in which the young man and snakes played a prominent part, she broke down and admitted the fact.

In conscious mind she knew she loved this young man; by autosuggestion and suggestion from others her subconscious mind accepted the fallacy that she hated him and wanted to kill him to avenge her father. The convulsions were the sublimation of this subconscious desire with accomplishment of the act. There have been no further convulsions since isolation and psychoanalyses.

NEWS AND COMMENT.

BULLETIN OF THE LOUISIANA STATE MEDICAL SOCIETY. The following is submitted for the information of the Chairman and personnel of each committee of the Louisiana State Medical Society, in order that they may have ample time in which to accomplish something in their respective field, before the annual meeting of the Society, April 10, 11 and 12, 1923:

STANDING COMMITTEES.

COMMITTEE ON SCIENTIFIC WORK: Dr. P. T. Talbot, Chairman; Dr. Hamilton P. Jones, New Orleans; and Dr. Elizabeth Bass, New Orleans, La.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION: Dr. Homer Dupuy, Chairman, New Orleans; Dr. Paul J. Gelpi, New Orleans; Dr. W. H. Block, New Orleans; Dr. W. D. Phillips, New Orleans; Dr. P. T. Talbot, New Orleans.

COMMITTEE ON PUBLICATION: Dr. P. T. Talbot, Chairman, New Orleans; Dr. Amedee Granger, New Orleans; Dr. C. J. Gremillion, Alexandria, La.

COMMITTEE ON BUDGET AND FINANCE: Dr. Amedee Granger, Chairman, New Orleans; Dr. L. L. Cazenavette, New Orleans; Dr. M. J. Lyons, New Orleans; Dr. C. M. Horton, Franklin, La.; Dr. C. G. Cole, New Orleans.

COMMITTEE ON MEDICAL EDUCATION: Dr. C. W. Allen, Chairman, New Orleans; Dr. B. W. Smith, Franklin; Dr. F. T. Gouaux, Lockport.

COMMITTEE ON MEDICAL DEFENSE: Dr. R. O. Simmons, Chairman, Alexandria; Dr. J. C. Willis, Shreveport; Dr. P. T. Talbot, New Orleans.

SPECIAL COMMITTEES.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION: Dr. E. L. Leckert, Chairman, New Orleans; Dr. W. H. Seemann, New Orleans; Dr. T. A. Roy, Mansura; Dr. J. M. Mosely, Arcadia, La.

COMMITTEE ON HOSPITALS: Dr. P. Graffagnino, Chairman, New Orleans; Dr. L. J. Menville, New Orleans; Dr. R. O. Simmons, Alexandria; Dr. E. M. Ellis, Crowley; Dr. C. M. Horton, Franklin.

COMMITTEE ON VIVISECTION: Dr. C. C. Bass, Chairman, New Orleans; Dr. F. M. Johns, New Orleans; Dr. R. D'Aunoy, New Orleans; Dr. Maurice Couret, New Orleans.

COMMITTEE ON HEALTH PROBLEMS IN EDUCATION: Dr. J. M. Bodenheimer, Chairman, Shreveport; Dr. R. O. Simmons, Alexandria; Dr. J. D. Tuten, Lake Charles; Dr. W. B. Chamberlain, Baton Rouge; Dr. R. W. Faulk, Monroe, La.

The Society will expect a report from the Chairman of each Committee, on their respective workings and accomplishments during the year, to be read at the annual meeting in New Orleans.

Dues, for the year 1923, Louisiana State Medical Society, are now being accepted in the office of the Society, No. 1551 Canal Street, New Orleans, La. If your Parish IS organized, send your dues in to the Secretary or Treasurer of your Parish Society. If your Parish is NOT organized kindly make check payable to the Louisiana State Medical Society, in amount $4.00 and mail direct to the office of the Secretary of the State Society.

DR. ALLEN EUSTIS, DR. I. I. LEMANN AND DR. C. W. DUVALL, all of New Orleans, attended the meeting of the Federation of Biological Scientists held in Toronto, Canada, December 28-29, 1922.

THE SEMI-ANNUAL EXAMINATION of the Louisiana Nurses Board of Examiners was held in New Orleans and Shreveport, December 18-19, 1922, at which time fifty-four applicants qualified as registered nurses. The Board conducting the examination was composed of: Dr. J. T. Crebbin, Dr. J. S. Hebert, Dr. G. S. Brown, Dr. F. J. Frater, and Dr. R. W. Faulk.

DR. J. M. BATCHELOR, NEW ORLEANS, recently accepted the post as chief surgeon of the Presbyterian Hospital, New Orleans.

NEW ORLEANS HAS BEEN CHOSEN, by the National Association of Public Health Nursing, as one of the thirteen American cities in which a survey will be made relative to certain phases of public health nursing. The local organization to be studied is the Child Welfare Association.

DR. J. A. DANNA, NEW ORLEANS, was recently elected to the Board of Governors of the American College of Surgeons.

A NEW MATERNITY CLINIC has been opened by the Child Welfare Association at Flood and Dauphine streets, New Orleans. Dr. J. B. Rateau will be in charge. Later other clinics will be opened, one for negro women at 2525 Delachaise street, under

Dr. R. J. Coker, and a baby clinic at 1900 Delachaise street, under Dr. R. de la Houssaye.

THE FIRST ANNUAL GROUP MEETING of the Louisiana-Mississippi-Arkansas Section of the American College of Surgeons convened in Shreveport on January 22 and 23.

This session included clinics and clinical demonstrations on the morning of the two days of meeting; scientific sessions where papers relating to the science and art in surgery were read and discussed; a hospital conference and a mass meeting for the laity at which distinguished orators presented brief addresses in non-technical language on vital topics on public health and preventive medicine. A detailed program was prepared.

All arrangements were made by the following committee: Thomas Ragan, M.D., Chairman; Louis Abramson, M.D., John A. Hendrick, M.D., Alfred Penn Crain, M.D., Rawley M. Penick, M.D., John L. Scales, M.D., James Clinton Willis, M.D.

THE TUBERCULOSIS HOSPITAL FOR NEW ORLEANS was discussed before the Commission Council during last month and the Council finally decided against the Derby tract of land for the proposed buildings. An attempt is being made to re-open the case with the Council. It is to be hoped that soon this matter will be settled for the City as well as the State need this institution badly.

DURING THIS MONTH a steamer will leave New York for South America carrying a large delegation of North America's surgeons. The trip is that of the American College of Surgeons, and no doubt the visit our fellows will make to the Latin-American countries will result in mutual benefit.

DR. C. R. CAMPBELL, SAN ANTONIO, TEX., addressed the New Orleans Association of Commerce recently on "Bats." He asserted that the bat is the most available and effective weapon in mosquito extermination.

DIPHTHERIA IS ON THE DECLINE, according to figures furnished by the New Orleans Department of Health.

MARINE HOSPITAL NO. 14, NEW ORLEANS, has been instructed by Surgeon General Cummings to furnish free medical advice by radio to ships at sea. This advice will be transmitted via the Algiers Naval Radio Station. The call for the Algiers station will be "NAT."

RESOLUTIONS PASSED by the Board of Directors of the Loyola Post-Graduate School of Medicine:

WHEREAS it has pleased an all-wise Providence to remove from this mortal sphere, Charles Ansley, our friend and co-worker; and

WHEREAS Charles Ansley was associated with the Loyola Post-Graduate School of Medicine in the capacity of Clinical Assistant, which he ably filled, using his keen faculties, deep knowledge of medicine and untiring efforts in the advancement of Science and the upbuilding of our institution; and

WHEREAS the members of this entire Faculty suffer personally as well as professionally, an unreplaceable loss in the passing of their loyal friend, deep student and able teacher; therefore, be it

RESOLVED, That the Board of Directors of the Loyola Post-Graduate School of Medicine expresses its sincere appreciation of our lamented colleague for the splendid services which he rendered to Medical Science and to this school, and that it voices its feeling of irreparable loss now that his knowledge, skill and unselfish efforts can no longer be displayed in the interest of this school and of its students.

RESOLVED, FURTHER, That copies of this resolution be forwarded to his bereaved family, expressing to them our sincere condolences in their great sorrow.

AT A RECENT MEETING OF THE CENTRAL COUNCIL OF SOCIAL AGENCIES the following officers were elected to serve for the ensuing year: Professor G. P. Wyckoff, President; Mrs. F. C. Coleman, Vice-President; Galen F. Achauer, Secretary; William Pfaff, Treasurer; Executive Committee: H. L. Hammett, Miss Mathilde Godchauz and Dr. Walter J. Otis.

LOUISIANA RADIOLOGICAL SOCIETY held their annual meeting in New Orleans on January 13, 1923. The retiring officers were as follows: President, Dr. Barrow, of Shreveport; Vice-President, Dr. Williams, of Baton Rouge; Secretary-Treasurer, Dr. T. I. St. Martin, of Houma. The officers for 1923 are: Dr. L. A. Fortier, President, New Orleans; Dr. Rutledge, Vice-President, Shreveport; Dr. Edwards, Secretary-Treasurer, Lafayette. The meetings of the Society are held annually in New Orleans.

THE RADIOLOGICAL DEPARTMENT OF HOTEL DIEU announces that it is now completely equipped for clinical photography.

THE STATE MEDICAL SOCIETY OF CALIFORNIA is making elaborate preparations for the seventy-fourth meeting of the American Medical Association to be held the last week in June, in San Francisco.

THE ST. LANDRY PARISH MEDICAL SOCIETY met January 10, 1923, upon call of the President, with Dr. S. B. Wolff, President, presiding, and the following members present: Drs. R. M. Littell, A. B. Pavy, W. R. Boudreaux, Paul Foster, E. Lafleur, F. C. Shute, J. P. Saizan, F. J. Mayer, C. A. Gardiner and B. A. Littell.

The President stated that the purpose of the meeting was the election of officers of this Society for the year 1923 and a delegate and alternate delegate to the meeting of the Louisiana State Medical Society, and for the transaction of any other business that might be brought before the Society.

An election was held and the following officers were elected: Dr. Paul Foster, President; Dr. S. B. Wolff, Vice-President; Dr. A. B. Pavy, Secretary-Treasurer; Dr. W. R. Boudreaux, Delegate to State Society; Dr. E. Lafleur, Alternate Delegate to State Society.

Dr. R. M. Littell moved that a committee of three be appointed to meet with the Parish Board of Health to ascertain the status of a physician attending contagious and infectious diseases in the absence of the health officer. Motion was duly seconded and carried. The Chair appointed Drs. R. M. Littell, W. R. Boudreaux and Paul Foster on this committee.

Dr. R. M. Littell moved that a committee of three be appointed to revise the fee bill of this Society and report at the next meeting. This motion was duly seconded and carried. The Chair appointed Drs. B. A. Littell, F. C. Shute and A. B. Pavy on this committee.

Dr. R. M. Littell moved that the delegate to the State Society meeting be instructed to extend to the State Medical Society an invitation to hold their annual meeting of 1924 in Opelousas. This motion was duly seconded and carried.

Dr. Foster moved that Dr. F. J. Mayer be appointed a special delegate to the State Society for the purpose of working to the

end to obtain the 1924 meeting. This motion was duly seconded and carried.

Dr. Foster, the newly-elected President, delivered an address to the Society stressing the importance of the Parish Medical Society and invoking the active co-operation of the members of the Society in making a means of improving the welfare of the physicians and their patients throughout our parish.

On motion, duly seconded and carried, the meeting adjourned subject to call of the President.

AT THE CHARITY HOSPITAL, NEW ORLEANS: Charity Hospital is supported in large part by an appropriation from the State. However, this is not the sole source of income. The next largest donors on our list are the Slaughter House, auctioneers' fees and the City of New Orleans, from which we receive an annual amount for the Social Service Department.

There are a number of firms and individuals who make donations to the Hospital; some of these donors make a contribution to the Hospital one of their annual charities. The gifts are not always money, but frequently take the form of clothing, food, and supplies of all descriptions. Several of the buildings of the Hospital are the results of gifts from private individuals.

Permits for dances, entertainments, etc., for which an admission fee is charged, furnish the other source of revenue. These permits are issued in the office of the Secretary, in accordance with provisions made by the State Legislature.

DR. ERNEST LEWIS, representing the Louisiana Anti-Tuberculosis League, expressed himself in favor of the proposed plan to request the patrons of the Cumberland Telephone Company to dedicate their "refund money," which is coming to them by the recent decrease in 'phone rates, to the establishment of a state tuberculosis hospital at Greenwell Springs.

DEATHS: Dr. John W. Caldwell, former head of department of chemistry at Tulane, died in New Orleans, January 2, 1923.

Dr. H. A. Gabert, residing in Mandeville, La., died January 13, 1923.

Dr. G. H. Tichenor died in New Orleans, January 15, 1923.

BOOK REVIEWS AND NOTICES.

All new publications sent to the JOURNAL will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the JOURNAL to review as many of the works accepted as possible, the editors will be guided by the space available and the merit of respective publications. The acceptance of a book implies no obligation to review.

Diseases of the Thyroid Gland, by Arthur E. Hertzler, M.D., F.A.C.S., St. Louis, Mosby, 1922.

This study on the part of Dr. Hertzler adds another volume to the bookshelf prepared by Dr. Hertzler on various subjects.

As most of us remember, his contributions have included volumes on Case Histories, a work on Tumors, Local Anesthetics, and a two-volume work on the Peritoneum. All of this gives evidence of the activity of the individual.

It is amazing and unusual to find one so active in the literary field, when not under the influence of active associations and competition with medical men in a large medical center.

The author has attempted, in this volume, to present all phases of the thyroid problem from the various hypothesis as to the origin of thyroid diseases to, and including the operative technique. The inclusion in one volume by a single author of normal and pathological anatomy, symptoms, etiology, and the appraisement of the merits of the various tests of functional activity of the thyroid gland is more than one can be expected to do well.

Unfortunately the classification of thyroid diseases is just a bit different from one generally accepted at the present time. This adds unnecessary confusion in the minds of the reader.

The author attaches little importance to Basal Metabolism, and to the Goetsch test.

The chapter on the management of Goitre patients is interesting, because it gives the individual surgeon's point of view.

The review of the anatomy of the cervical region is interesting, and the illustrations are good. The operative technique as described gives a fair idea of the author's methods.

On the whole it is a book which will prove interesting reading for the surgeon who has witnessed thyroid work in the great clinics of the country. It is not such a book as could be recommended to the student, or to the occasional operator who has not read the great works of Crile, and of the Rochester Clinics, and many others who have done so much to standardize the treatment of thyroid diseases.

I. C.

Treatise on Fractures in General, Industrial and Military Practice, by John B. Roberts, A.M., M.D., F.A.C.S., and James A. Kelly, A.M., M.D., 2d Edition, revised and entirely rewritten. Phila., J. P. Lippincott Co., 1921.

The second edition of this valuable book is a welcome addition to the surgeon's library on fractures. This volume is one of the most useful books on fractures which the student could use for reference.

Unfortunately too little space is given by the author to methods of suspension and traction. This is particularly noticeable in chapters devoted to fractures of the femur. It is unfortunate that the author advocates Buck's extension, and sand bags in treatment of fractures of the neck of the femur.

In spite of evident room for difference in opinion in regard to the various fractures concerned, one cannot help appreciating the great value of the work, because of the splendid manner of present-

ing the importance of muscular action in the production of deformity.

On the whole I believe it to be the best single volume on fractures in general for the average student. I. C.

The Newer Knowledge of Nutrition, by E. V. McCollum, Ph.D., Sc.D. Second Edition, revised. The MacMillan Company, New York, 1922.

This book is of great interest not only to students of nutrition but to practitioners in general. It is a careful summary and interpretation of the existing data relating to nutrition. In the first seven chapters the author describes and correlates the experimental studies which have led to a more exact knowldge of the processes of nutrition. He discusses clearly the nutritive value of the proteins and their peculiarity of composition, also the dietary properties of foodstuffs and their vitamin content. The remaining chapters are concerned mainly with dietary deficiency diseases as scurvy, beriberi, polyneuritis, xerophthalmia and the relation of other diseases as pellagra and rickets to diet. It is of interest to note that the author has altered his former views upon the etiology of scurvy as an infectious disease and now considers it a dietary deficiency disease due chiefly to a lack of one of the vitamins, water soluble C. He apparently believes that pellagra is a dietary disease and can be prevented by a satisfactory regimen, although admitting from the conflicting evidence in the literature that it is not possible at present to formulate any satisfactory theory concerning its etiology. The concluding chapters on the dietary habits of man and preventive dentistry alone would be well worth the cost of the book to the practitioner. R. L.

Ephraim McDowell, Father of Ovariotomy and Founder of Abdominal Surgery, with an Appendix on Jane Todd Crawford, by August Schachner, M.D., F.A.C.S. Phila., J. B. Lippincott Co., 1921.

The author has rendered a great service to American surgery by recording the story and life work of McDowell, and the story of the heroine, Jane Crawford.

He pays a beautiful tribute to early American life, that it was the pioneer life that served as a stimulus to individual thought and action.

The work by McDowell is contrasted to work of surgeons living in the atmosphere of Old World universities, hampered by conventionalities and bound by the teachings of masters.

Epoch-making achievements such as McDowell's are often unnoticed by surgeons, who know too little of the facts which have paved the way for present methods.

Painstaking studies such as Schachner's should be a stimulus to others to learn more of the facts of the past which have made our present technical developments possible.

Great credit is due the author for the work which he has done. All students should read this story and profit by it. I. C.

Hay Fever and Asthma: Care, Prevention and Treatment, by William Scheppegrell, A.M., M.D. Philadelphia, Lea & Febiger, 1922.

This splendidly illustrated volume epitomizes our present-day knowledge of hay fever. The botanical aspect of the subject, with a classification of the hay fever plants, furnishes valuable information. The photomicrographs are original. The etiologic relation of pollen is duly emphasized. Active immunization by the injection of pollen extract is explained in the clearest terms. The author admits with Koesler and other workers that in many cases we must combine vaccine and pollen therapy. Despite the note of optimism in

the chapter on Therapy we feel that the last word is yet to be said in the treatment of this disease. It is surely, however, going to be along lines of immunization, so we are on our way, at least, to a seasonal cure. This volume will help diffuse up-to-date knowledge on this very important subject. It is cause for congratulation that such a worthy contribution emanates from a member of our local profession. H. D.

Operative Story of Goitre, by William Stewart Halsted, A.B., M.D., LL.B., D.Sc., F.A.C.S. Baltimore, Johns Hopkins Press, 1919.

This is one of the most valuable historic reviews on any subject with which I am familiar. On every page there is valuable information for the student of the surgery of goitre. No man should feel that he is conversant with the story of the development of this subject unless he is familiar with this epoch-making volume.

Startling facts are revealed in the first few pages, among these may be mentioned that the author states that from 1880-86, that he did not see nor hear of an operation of a goitre except a case operated by Dr. Sands. Historically this is of importance.

Luigi Porta was the first to ligate the inferior thyroid as a preliminary step in operations for goitre. The date of this operation was July 28, 1850.

Dupuytren, in 1817, in describing thyroid surgery, placed his ligature "on the side corresponding to the brain" in order to avoid prolonged pain, which without this precaution would follow the application. Halsted, commenting on this, states that it is interesting to find reference to the sensitiveness of the artery. Desault, as early as 1792, noted cartilage in diseased thyroids.

Prior to 1883, only 45 operations for goitre could be found reported in the literature of America.

The part played by Theodorus Billroth and Theodor Kocher is wonderfully presented.

Kocher is credited with many single contributions on this subject, among these he mentions first: "that total extirpation of the thyroid is followed by a condition which he named cachexia thyreopriva; perfecting the operation of thyroidectomy; demonstration of the value of ligation of artery as a preliminary step to lobectomy in highly toxic cases; and the danger of indiscriminate use of iodine to patients with gotire."

The operation devised by Halsted, and practiced by him and his associates is described in detail in this work.

The last paragraph of the work contains a summary which clearly outlines why the operative method was gradual in its development as it was dependent on the knowledge of the control of hemorrhage, anesthesia, asepsis and antisepsis which had to be gained before this surgical procedure could be perfected.

This skeleton outline will serve to stimulate others to read this wonderful contribution, the pubilcation which came so near the end of Professor Halsted's life is like a beautiful swan song.

I. C.

Diseases of the Stomach and Upper Alimentary Tract, by Anthony Bassler, M.D., F.A.C.P., Fifth Edition, revised and enlarged. F. A. Davis Co., Philadelphia, 1922.

The fifth edition of this volume, like the previous ones, details the many clinical and technical methods in use in the modern diagnosis and treatment of stomach disorders. The X-ray is given just credit for its valuable aid as an adjunct in the diagnosis of gastric and duodenal lesions. This subject chapter is distinctly written and profusely illustrated. A new edition to the causes of functional disorders of the stomach, in conformity with the trend of to-

day's medicine, resolves itself into disturbances of the endocrine organs. Many derangements in motility and secretion of the alimentary tract may depend on improper stimulation by the products of these glands. The ways in which these products act are gradually being worked out.

The author's consideration of the upper digestive tract, other than the stomach, is somewhat limited in this volume. There is no attempt to elucidate upon the many valuable tests applied to the duodenal contents, the most important fluid of a digestive nature.

D. N. S.

Infant Feeding, by Clifford G. Grulee, A.M., M.D., LL.D., fourth edition. W. B. Saunders Co., Philadelphia, 1922.

This edition includes a resume of all the scientific works and publications up to April 1, 1921. For those of us who care to follow the schools of Finkelstein, Czerny and Keller, Meyer and numerous other celebrities of the Far East, this compilation of facts is a source of untold interest. This unique book should grace the library of every physician interested in diseases of children, for even though we may not accept the views propounded, there is sufficient interest not directly relating to the question of feeding to warrant the purchase of this volume.

C. J. B.

Radium Therapy, by Frank Edward Simpson, A.B., M.D. St. Louis, C. V. Mosby Co., 1922.

This work of Simpson is the best book of its kind ever written in the English language.

The technic of radiation as suggested by the author is made clear and simple, representing the methods employed by the best radiologists.

The illustrations are numerous, clear and interesting. No radiologist can afford to be without this masterpiece.

"I Believe in God and in Evolution," by William W. Keen, M.D. Philadelphia, J. B. Lippincott Co., 1922.

In proving the solidarity of all animal life, the versatile Keen draws from his own rich experience as a surgeon and anatomist. While addressed to a lay audience, the busy doctor will find this little volume thought-provoking. The seeker after truth will approach the evolution of man from the medical side.

H. D.

Food, Health and Growth, by L. Emmett Holt, M.D., LL.D. Macmillan Co., New York, 1922.

This little volume of two hundred and sixty-one pages contains the Lane lectures delivered in December, 1921, at the Medical School of the Leland Stanford Junior University. These lectures are five in number, are printed exactly as they were delivered, and include much that would interest the layman as well as the physician. Such topics as Nutrition in Relation to Growth, The Food Requirements of Children during the Entire Period of Growth, The Conditions upon which are based the Requirements for Fat, Protein, etc., Vitamins, and The Practical Means by Which the Nutrition of Children may be Improved, have been discussed with simplicity of expression, brevity of thought, and a suffcient bit of added scientific mention, to make the book of inestimable value to all interested in the problems of the modern-day child and the various phases associated with child life.

To reduce the death rate of children from 280 to 86 per 1000 in the City of New York, is well nigh remarkable—accomplished how—by the concentrated efforts of all concerned in this work, through educational measures principally when one considers that our Federal Government spent last year $9,700,000 in appropriations for the Department of Animal Industry, and only $271,000 for the

maintenance of the Children's Bureau, established in 1912. The deduction is simple—even the Federal Government has only given the child, its future citizen, a passing thought.

The every-day topics of vitamins and calories of the principal foods included in the diet of children will be well received at this time. While there is nothing basic in the formulae, there is sufficient interest in this chapter to educate the present-day food fanatic.

On the whole the author deserves the thanks of the nation for publishing another book which will be received in the same enthusiastic way as were the other standard works which have preceded this one. C. J. B.

Practical Organotherapy: the Internal Secretions in General Practice, by Henry R. Harrower, M.D., F.R.S.M. (Lond.), third edition. Harrower Laboratory, Glendale, Cal., 1922.

A complete and abbreviated resume of therapeutic indications for the alleviation of supposed errors of glandular secretions with especial reference to the composition of pluriglandular formulae, as prepared by the Harrower Laboratory, with a distinct plea for their use. Other than being a ready reference index for one accustomed to the use of Harrower preparations, it might also serve as a ready reference to one well versed, experimentally and thrapeutically, in the handling of such diseases. P. T. T.

PUBLICATIONS RECEIVED.

F. A. Davis Company, Philadelphia: Diseases of the Ear, Nose and Throat, by Wendell Christopher Phillips, M.D., sixth edition, revised; Principles and Practice of Infant Feeding, by Julius H. Hess, M.D., third edition, revised; Feeding, Diet and the General Care of Children, by Albert J. Bell, A.B., M.D.

Paul B. Hoeber, New York: Montaigne and Medicine, by James Spottiswoode Taylor, Commander, M.C., U. S. Navy.

J. B. Lippincott Company, Philadelphia and London: Text-Book of Pediatrics, edited by Prof. E. Feer, translated and edited by Julius Parker Sedgwick, B.S., M.D., and Carl Ahrendt Scherer, M.D., F.A.C.P. First edition in English.

Washington Government Printing Office, Washington, D. C.: Annual Report of the Surgeon General of the Public Health Service for the Fiscal Year 1922; Public Health Reports, Vol. 37, Nos. 49, 50, 51, 52.

Miscellaneous: Transactions of the American Otological Society, Fifty-fifth Annual Meeting, May 1, 2 and 3, 1922., Vol. 16, Part 1; Observations on an Outbreak of Cattle Anthrax in the Sudan, by R. G. Archibald, D.S.O., M.D.

REPRINTS

Factors Contributing to the Increase of Cancer Mortality, by L. Duncan Bulkley, A.M., M.D.; **Trypanosoma Rhodesiense in a Case of Sleeping Sickness from the Sudan; Tuberculosis in the Sudan, with Notes on a Case of Breast Tuberculosis Sudanese,** by R. G. Archibald, D.S.O., M.D.; **Dispensary Service in the United States, 1922; Public Health, Nos. 754, 761, 770, 785.**

STATISTICAL DATA FOR THE MONTH OF DECEMBER OBTAINED FROM THE RECORDS OF CITY BOARD OF HEALTH.

BIRTHS.

December, 1922—	White	Colored
Male	340	146
Female	338	110
Totals	678	256
By Physicians		485
By Midwives		449
Grand Total		934
Stillbirths		34

DEATHS.

	1921			1922	
	White	Colored		White	Colored
Male	184	124	Male	204	111
Female	150	114	Female	176	142
Totals	334	238	Totals	380	253
Under 1 year	69		Under 1 year	98	

December, 1922—	Cases		Deaths	
	White	Colored	White	Colored
Diphtheria	115	10	8	0
Typhoid	22	2	2	0
Malaria	3	2	0	1
Scarlet Fever	24	3	0	1
Whooping Cough	8	0	2	0
Influenza	3	2	3	2
Measles	7	0	0	0
Cs. Meningitis	1	1	1	1
Tuberculosis	52	42	34	25

DEATHS.

December, 1922—	White	Colored
Cancer	41	12
Apoplexy	30	21
Endocarditis and Myocarditis	25	15
Angina Pectoris	6	1
Other Circulatory Diseases	40	31
Bronchopneumonia	26	23
Lobar Pneumonia	12	14
Other Respiratory Diseases	4	1
Diarrhoea and Enteritis	9	9
Appendicitis	5	3
Other Digestive Diseases	4	2
Acute Nephritis	8	5
Chronic Nephritis	22	14
All Other Genito-Urinary Diseases	3	5
Puerperal State	3	3
Malformations	26	19
External Causes	23	18

DEATH RATE PER 1,000 PER ANNUM FOR THE MONTH.

December, 1922—		Non-residents Excluded:
White	15.46	12.82
Colored	27.60	23.89
Total	18.75	15.84

Deaths from Premature Births, Violence, etc., are excluded.